

**PRACTICE GUIDELINES  
FOR THE TREATMENT OF ADULTS  
WITH CO-OCCURRING SUBSTANCE USE  
DISORDERS AND MENTAL ILLNESS**



A Report Submitted to the Missouri Department of Mental Health  
Steering Committee for Practice Guidelines

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# I. Executive Summary



## I. Executive Summary

In January 2001, our Writing Team was convened to develop Practice Guidelines for the Treatment of Adults with Co-Occurring Substance Use Disorders and Mental Illness. Epidemiological data suggests that more than 50% of individuals with a mental illness have a co-occurring substance use disorder, and vice versa. Research further suggests that individuals with co-occurring disorders have poorer outcomes in treatment, and are at greater risk for relapse, suicide, homelessness, incarceration, discharge from treatment against medical advice, and infectious diseases including HIV/AIDS.

After review and discussion of literature, the group reached consensus and decided to focus the Guidelines on adults with a severe (serious and persistent) mental illness, such as schizophrenia or bipolar disorder, and a substance use disorder. People with these disorders are often most in need of effective treatment, yet studies suggest that treatment is often fragmented and ineffective. However, research and theory regarding treatment for individuals with serious and persistent mental illness and substance use disorders suggests that integrated treatment, that combines effective components of mental health and substance abuse treatment and that includes an integrated service system, can be more effective and efficient than fragmented systems.

The current fiscal and administrative systems in the State of Missouri separate Alcohol and Drug Abuse (ADA) and Comprehensive Psychiatric Services (CPS), although many individuals need assistance from both divisions. Despite the separation between ADA and CPS, a few Missouri providers have found ways to utilize both funding streams and administrative systems to provide integrated treatment to people with co-occurring disorders. The Guidelines review these model programs and outline procedures to assist other providers in developing integrated treatment programs.

It will be necessary for the State of Missouri to develop a philosophy that addresses several issues regarding co-occurring disorders:

1. Co-occurring disorders are an expectation rather than an exception.
2. Severe mental illness and substance use disorders are chronic, relapsing illnesses.
3. Treatment of individuals with these disorders needs to be provided by teams of professionals who offer services that are integrated on a variety of levels.
4. Persons with co-occurring disorders present themselves in different phases of treatment and recovery and in different stages of motivation and readiness to change.
5. A longitudinal perspective on co-occurring disorders treatment should be adopted emphasizing a comprehensive array of interventions that are phase and stage specific.

The vision discussed in the Guidelines is that:

1. Integrated treatment for co-occurring disorders is a best practice;
2. People with co-occurring disorders (severe mental illness and active substance use disorder) should have access to integrated treatment;

3. Within the current budget/funding constraints, methods and examples of integrated treatment programs are available;
4. Although not all providers will have an integrated treatment program, all agencies should be sensitive to the needs of people with all types of co-occurring disorders (e.g., provide adequate assessment, appropriate referrals, etc.).

## II. Introduction



## II. Introduction

### A. Purpose, Philosophy, Vision

Within these Guidelines, “co-occurring disorders” refers to concurrent mental illness and substance use disorders. Co-occurring disorders can refer to a combination of one or more of any DSM-IV (APA, 1994) Axis I and/or II mental illness and one or more of any substance use disorder (abuse or dependence). However, most research reviewed in these Guidelines was conducted on clients with a severe (serious and persistent) mental illness (such as schizophrenia or bipolar disorder) and an active substance use disorder (as opposed to one in remission). Moreover, recommendations regarding integrated treatment specifically refer to clients with this class of co-occurring disorders (New York State Generic model Quadrant 4 discussed below).

Research and theory regarding treatment for individuals with serious and persistent mental illness and substance use disorders suggests that integrated service systems can be more effective and efficient than fragmented systems (Drake & Wallach, 2000; Drake et al., 2001; Mueser, Drake, & Noordsy, 1998). Within the current fiscal and administrative system in the state of Missouri, Alcohol and Drug Abuse (ADA) and Comprehensive Psychiatric Services (CPS) funding streams are separate. Yet many individuals need assistance from both divisions. Despite the separation between ADA and CPS, a few Missouri providers have found ways to utilize both funding streams and administrative systems to provide integrated treatment to consumers with co-occurring disorders. We have chosen to write practice guidelines to review these model programs and outline procedures to assist other providers in developing integrated care programs using existing ADA and CPS funding streams.

Within Missouri, a philosophy regarding the treatment of co-occurring disorders needs to be developed that addresses several issues regarding co-occurring disorders. (1) Co-occurring disorders are an expectation rather than an exception. (2) Severe mental illness and substance use disorders are chronic, relapsing illnesses. (3) Treatment of individuals with these disorders needs to be provided by teams of professionals who offer services that are integrated on a variety of levels. (4) Persons with co-occurring disorders present themselves in different phases of treatment and recovery and in different stages of motivation and readiness to change. And, (5) A longitudinal perspective on co-occurring disorders treatment needs to be taken which emphasizes a comprehensive array of interventions that are phase and stage specific.

The vision discussed herein is that:

1. Integrated treatment for co-occurring disorders is a best practice;
2. Every client with co-occurring disorders (severe mental illness and active substance use disorder) should have access to integrated treatment;
3. Within the current budget/funding constraints, there are ways to develop integrated treatment programs;
4. Although not all providers will have an integrated treatment program, all agencies should be sensitive to the needs of clients with all types of co-occurring disorders (e.g., provide adequate assessment, appropriate referrals, etc.).



These guidelines provide general principles for integrated treatment programs, and a model of treatment that includes: outreach and engagement, assessment, treatment and rehabilitation, systems needs, consumer/family issues, and issues related to treatment of special groups. It also covers agency and provider competencies, two model programs in Missouri, issues specific to Missouri, and dissemination of the Guidelines.

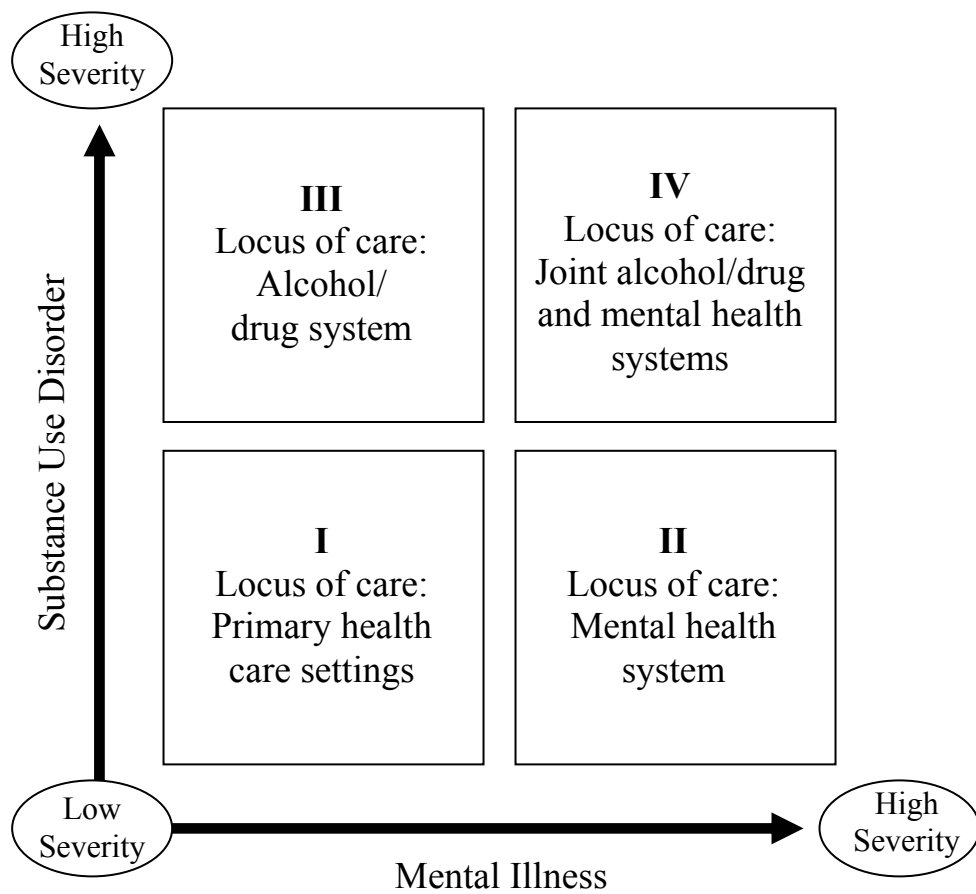
## **B. Practice guidelines initiative**

To help build an evidence-based mental health treatment system, national groups and states are developing practice guidelines that describe best practices for specific disorders and populations. In 2000, the Missouri DMH launched a *Practice Guidelines Initiative* to develop and implement “guidelines to assist consumers and practitioners in decision-making about treatment, services, and supports for person with specific diagnoses and/or levels of care and for the implementation of specific services within the constraints of available resources, based on a consensus about the best scientific or other information available” (Missouri DMH, 1/10/01).

### Writing Team Process

The following process was used to develop these guidelines. Our Writing Team, a statewide group of consumers/family members, experts, clinicians, DMH staff, and other stakeholders, was convened in January 2001. The Writing Team turned to the Missouri Institute of Mental Health’s (MIMH) Library staff who conducted an exhaustive literature review on co-occurring disorders. Over 1200 abstracts were returned from this search, and two sets of three team members reviewed them for content areas. It was determined that the majority of the abstracts referred to epidemiological studies. We then attempted to narrow our topic through several Team meetings, and had decided to review literature on individuals with co-occurring severe mental illness, substance use disorders, and Axis II personality disorders. The MIMH library conducted a more focused literature search that resulted in 125 abstracts; however, only a handful were treatment-related. We then examined the New York State generic model of locus of care based on severity of mental illness and substance use disorder that was presented in the 1998 joint NASMHPD/NASADAD report entitled “National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders” (see Figure 1). This model suggests that clients with severe (serious and persistent) mental illness and severe (active, chronic) substance use disorders fall under a locus of care that includes both alcohol/drug and mental health service systems (quadrant IV). Clinical wisdom suggests that this group is most in need of effective treatment, yet may be most likely not to receive adequate treatment. Clients with a severe mental illness have difficulty completing substance abuse treatment programs, in part because their symptoms may hinder their ability to pay attention during group treatment and/or they may disrupt group treatment. These clients may also be more likely to “fall through the system cracks” as they are difficult for providers to engage and treat successfully. Thus, we chose to focus on *adults with severe mental illness and active substance use disorders*. For the purposes of these guidelines, the term “co-occurring disorders” refers just to those severe disorders.

Figure 1  
New York State generic model of locus of care



With this target population in mind, the Writing Team then concentrated on finding research articles of treatment studies as well as recent review articles published in peer-reviewed journals. We also solicited examples of practice guidelines and other national consensus papers written about treatment for co-occurring disorders. From these searches were returned one major review article, one meta-analysis and six recent studies (see Table 1), and ten key guidelines and reports (see Table 2). Two subgroups of team members read either the guidelines or the studies.

Table 1. Major Review Article, Meta-analysis, and Studies

2001, review article	Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., Lynde, D., Osher, F. C., Clark, R. E., & Rickards, L. Implementing dual diagnosis services for clients with severe mental illness. <i>Psychiatric Services</i> , 52, 469-476. Reviews randomized controlled trials and quasi-experimental studies of integrated treatment.
2000, meta-analysis	Ley, A., Jefferey, D. P., McLaren, S., & Siegfried, N. Treatment programmes for people with both severe mental illness and substance misuse. <i>The Cochrane Library, Issue 4</i> . This is a meta-analysis of only the then available (1996) randomized controlled trials testing the effectiveness of integrated treatment.
2001	Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S. W., Moring, J., O'Brien, R., Schofield, N., & McGovern, J. Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. <i>American Journal of Psychiatry</i> , 158, 1706-1713. Integrated treatment was more effective than standard care regarding general functioning, psychiatric symptoms and substance use.
1999	Ho, A. P., Tsuang, J. W., Liberman, R. P., Wang, R., Wilkins, J. N., Eckman, T. A., & Shaner, A. L. Achieving effective treatment of patients with chronic psychotic illness and comorbid substance dependence. <i>American Journal of Psychiatry</i> , 156, 1765-1770. Using a sequential study group design, assertive case management (ACT) and relapse prevention skills training were more effective than traditional treatment.
1998	Drake, R. E., McHugo, G. J., Clark, R. E., Teague, G. B., Xie, H., Miles, K., & Ackerson, T. H. Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. <i>American Journal of Orthopsychiatry</i> , 68, 201-215. ACT was more effective in reducing substance use and increasing quality of life than standard case management.
1997	Drake, R. E., Yovetich, N. A., Bebout, R. R., Harris, M. & McHugo, G. J. Integrated treatment for dually diagnosed homeless adults. <i>Journal of Nervous &amp; Mental Disease</i> , 185, 298-305. A quasi-experimental study found that integrated treatment was clearly more effective than standard treatment in terms of institutional days, days in stable housing, and addiction recovery, and minimally more effective for psychiatric symptoms and quality of life.
1995	Jerrell, J. M., & Ridgely, M. S. Comparative effectiveness of three approaches to serving people with severe mental illness and substance abuse disorders.

	<i>Journal of Nervous &amp; Mental Disease, 183, 566-576. Intensive case management was more effective than Twelve Step recovery approach.</i>
1994	Godley, S.H., Hoewing-Roberson, R., & Godley, M. D. Final MISA Report. Bloomington, IL: Lighthouse Institute. This is a report of a study of the MISA model of integrated treatment in Illinois.

Table 2. Practice Guidelines and Manuals (all of which recommend integrated treatment)

2001	New Mexico (K. Minkoff). <i>Service Planning Guidelines for Co-occurring Psychiatric and Substance Disorders.</i>
2000	Arizona (K. Minkoff). <i>Service Planning Guidelines - Co-occurring Psychiatric and Substance Abuse Disorders</i> [Edited Version].
2000	Oregon, Department of Human Services, Statewide Task Force on Dual Diagnosis. <i>Final Report and Recommendations</i>
1999	Arizona, Integrated Treatment Consensus Panel. <i>Providing Integrated services for Persons with Co-occurring Mental Health and Substance Abuse Disorders. Implementation Plan - Phase I</i>
1999	Center for Substance Abuse Treatment [CSAT]. <i>Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse</i> , Treatment Improvement Protocol Series, Number 9, DHHS Publication No. (SMA) 99-3307, Department of Health and Human Services, Rockville, MD.
1999	NASMHPD/NASADAD. <i>Joint Report On Financing And Marketing The New Conceptual Framework For Co-Occurring Mental Health And Substance Abuse Disorders.</i>
1999	U.S. Department of Health and Human Services. <i>Mental Health: A Report of the Surgeon General</i> . Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
1998	Center for Mental Health Services [CMHS], Co-occurring Mental and Substance Disorders (Dual Diagnosis) Panel. <i>Co-occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula</i> . Kenneth Minkoff & Anne Rossi (panel chair and co-chairs)
1998	SAMHSA/NASADAD, <i>Release Report On Preliminary Information On Services To Individuals With Co-Existing Substance Abuse And Mental Health Disorders.</i>
1998	NASMHPD/NASADAD, <i>National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders.</i>

In addition to the literature review, the Writing Team commissioned a survey of current practice for treatment of individuals with co-occurring disorders in Missouri, which was carried out by MIMH and is detailed below.

The Writing Team met with Kenneth Minkoff, MD, in a special session just for team members at the Spring Training in May 2001. Dr. Minkoff is a nationally-recognized

expert on co-occurring disorders and integrated treatment. He has written several sets of practice guidelines for different states as well as the Center for Mental Health Services. Team members discussed integrated treatment with Dr. Minkoff, who reviewed several of the guiding principles of such treatment.

Also, the Team worked through several consensus-building processes, including developing consensus among the varied team members. Also, we presented a draft version of the Practice Guidelines at a meeting of Missouri Association of Psychosocial Rehabilitation Services in March 2002. The presentation included an overview of the guidelines and opportunities for attendees (approximately 30) to reply and comment in small groups. The Mid-America Addiction Technology Transfer Center (MATTC) facilitated this process and prepared a full report, including the following five major results:

- All participant groups reported a high level of agreement that providing service for consumers with co-occurring disorders was an important issue.
- All groups reported a high level of agreement that provider systems needed improvements to better serve this group of consumers.
- All groups reported a need for greater awareness of the issues surrounding co-occurring disorders.
- All groups reported a need for more training to improve skills and attitudes towards providing service for consumers with co-occurring disorders.
- All groups reported frustration at their ability to improve or provide services for consumers with co-occurring disorders.

We presented a draft version of the Practice Guidelines at the Spring Training Institute in May 2002. Writing Team members reported that approximately 20 providers attended that meeting, and noted that the feedback regarding the content of the guidelines was positive. Providers again expressed frustration in their ability to provide services to clients with co-occurring disorders and were particularly interested in what training would be provided in order to implement the guidelines.

### **C. Target population and Epidemiology**

Based on epidemiological data, Minkoff (2001) stated that co-occurring mental and addictive disorders are so common they “should be expected rather than considered the exception” (p. 597). Rates of comorbidity vary based on several factors: the diagnostic assessment, population (e.g. treatment sample vs. general population), interview timing in relation to withdrawal, diagnostic system (e.g. DSM-III, III-R or IV) (APA 1980, 1987 and 1994) as well as individual risk factors. Data from the National Comorbidity Study (NCS) demonstrated that 14% of adults aged 15 to 54 experienced both substance abuse and mental disorders in their lifetimes (Kessler et al., 1994). The Epidemiological Catchment Area (ECA) study found that rates of psychiatric disorders were increased for every category of DSM-III substance abuse or dependence (Regier et al., 1990). Overall, 53% of persons in the ECA with substance use disorders had evidence for one or more psychiatric conditions. Similarly, the NCS found that 47% of those with substance abuse or dependence

had additional psychiatric disorders, more than double overall population rates (Kessler et al., 1994, 1997). Alternately, the 51% of respondents with one or more lifetime mental disorder also have at least one lifetime substance use disorder (Kessler et al., 1994, 1997). Data from the ECA indicated that 29% of individuals with any lifetime mental disorder also had a substance use disorder (Regier et al., 1990).

Likewise, rates of comorbidity are higher in treatment populations. Among persons with substance abuse or dependence seeking treatment, comorbidity has been estimated at close to 65% during the past year and 78% over the subject's lifetime (e.g., Broome, Simpson, & Joe, 1999; Brooner et al., 1997; Penick et al., 1994; Ross, Glaser, & Germanson, 1988).

Specific to Missouri, in a 1999 statewide household survey, nearly 20% of adults were in need of intervention for alcohol or other drug use. Almost 40% perceived their mental health to be fair or poor and more than 20% had received services for mental health (Sanchez, Kuo, Akin, Moore, & Bray, 1999). Using more recent data, in 2001, approximately 25% of patients discharged from DMH acute care facilities were dually diagnosed (personal communication, Joseph Parks, MD, Medical Director, Missouri DMH, 3/14/2002). Moreover, co-occurring disorders appear to be underidentified in Missouri. Data suggest that although about 30% of clients currently being served by state substance abuse services had previously been served by state mental health services, almost two-thirds do not have a mental health diagnosis in their substance abuse records (suggesting that the substance abuse service provider did not adequately assess for mental health problems). Similarly, about 24% of current mental health clients had received substance abuse services in the past, but only half are recognized by mental health as having such a diagnosis.

#### **D. Negative Outcomes for Adults with Co-occurring Disorders**

Furthermore, research suggests that individuals with co-occurring mental health and substance use disorders have poor outcomes. Psychiatric symptoms among clients with substance use disorders are associated with higher rates of drug relapse following treatment (Cantor-Graae, Nordstroem, & McNeil, 2001; Mackenzie, Funderburk, & Allen, 1999; Wright, Gournay, Glorney, & Thornicroft, 2000). Overall, co-occurring disorders have been shown to complicate treatment of both disorders (Kranzler, Del Boca, & Rounsaville, 1996; Lennox, Scott-Lennox, & Bohlig, 1993). Individuals with severe mental illness and substance use problems report more psychiatric distress and less satisfaction with treatment (e.g., Pollack, Cramer, & Varner, 2000; Primm, Gomez, Tzolova-Iontchev, Perry, & Crum, 2000). The implications of co-occurring disorders are complex because persons with co-occurring disorders are at greater risk for relapse, suicide, homelessness, incarceration, and discharge from alcohol treatment against medical advice (Booth, Cook, & Blow, 1992; Caton, Shrout, Eagle, & Opler, 1994; Dinwiddie, Reich, & Cloninger, 1992; McCarty, Argeriou, Huebner, & Lubran, 1991). Further, persons with co-occurring disorders may be at higher risk of acquiring HIV (Compton, Lamb, & Fletcher, 1995; Compton, Cottler, Spitznagel, & Abdallah, 1998; Rosenberg et al., 2001).

## **E. Treatment Services are often Fragmented and Inadequate**

Historically, in the United States, mental health and substance abuse treatment have been separate systems, with separate facilities, treatment programs and philosophies, funding streams, professional identities, and training structures. They are not necessarily well-coordinated (Baker, 1993), nor typically organized to provide integrated services to persons with co-occurring disorders (Ridgely, Goldman, & Willenbring, 1990). A 1998 report by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) summarized results of state mental health and substance abuse agencies regarding treatment for co-occurring disorders. Although the responsibility for service provision had been assigned to a state agency in 80-90% of states, only half of state agencies had written policies or regulations regarding services for dually-diagnosed clients, less than half monitored effectiveness of treatment, and 80-90% reported significant barriers impeding provision of services.

Moreover, national studies of individuals with co-occurring disorders have found that few receive adequate treatment. For example, Watkins, Burnam, Kung, and Paddock (2001) analyzed data from a national household sample. Of respondents with likely current co-occurring disorders, during the previous year only 23 percent received appropriate mental health treatment (medication or counseling consistent with national guidelines), 9 percent received comprehensive substance abuse treatment, and 8 percent received integrated treatment.

### **Current Practices in Missouri**

In January 2002, a survey was distributed to all state-contracted alcohol and drug abuse (ADA) treatment providers and their affiliates, and to all state-contracted psychiatric/psychosocial (CPS) treatment providers. This included 220 sites. It did not include correctional or supported housing sites. The Department of Mental Health sponsored the survey, and encouraged sites to respond. Sites that did not respond were contacted and reminded to respond. A cover letter requested that the clinic director/program manager with direct supervision over the adult ADA or CPS program complete the survey. The four-page survey asked questions regarding treatment site procedures about content of assessments, factors considered in treatment planning, treatment services available, staffing patterns, and perceived barriers to service. Surveys were returned to MIMH, and the cover letter noted that MIMH was responsible for data analysis and reporting. Sites were advised that information collected from the surveys would only be reported in aggregate, individual agencies would not be identified.

Completed surveys were received from 159 sites. As 9 of the original 220 sites were no longer in operation, the return rate was 74%. Although 60% of sites stated that they provided co-occurring services, only four integrated treatment programs are known to exist in Missouri. Screening and assessments were variable in their coverage of both mental illness and substance abuse, with less than 70%

adequately screening all clients regarding substance use, with only 57% of sites assessing for relapse history on all clients. Readiness or motivation to change was assessed in all clients at only 22% of the sites. Less than 70% of substance abuse and/or mental health treatment sites have protocols regarding treatment planning for individuals with co-occurring disorders, and less than 80% have protocols for treatment collaboration for these clients. And a majority of sites noted that transportation and difficulties with medication were significant barriers to clients accessing services. Over 70% of sites stated that they need specialized funding and staff training to better serve adults with co-occurring disorders. In summary, results suggest that treatment services in the state are indeed fragmented and sporadic, and that dissemination of the Practice Guidelines is needed.

## **F. Integrated Treatment for Individuals with Co-occurring Disorders**

Within the past two decades, treatment providers and researchers have become more aware of the needs of individuals with co-occurring disorders. Much of this research has focused on providing an "integrated treatment approach," defined as combining elements of both mental health and substance abuse treatment into a unified program. Integrated treatment can take the form of an assertive community treatment team, intensive outpatient treatment, or inpatient/residential treatment. Ley et al. (2000) reviewed a small group of older (pre-1998), small randomized trials of integrated treatment. They noted that the studies were not of high quality and concluded that there was not clear evidence of a benefit for integrated treatment. However, Drake et al. (2001) reviewed newer research, and suggested that although older studies showed poor results for treating clients with traditional substance use treatment models, more recent studies have stressed the inclusion of more effective substance use treatment components including motivational interviewing and outreach/engagement. At least eight recent studies, some of which are also more methodologically sophisticated, find improved outcomes for clients treated in an integrated program (see Table 1).

In fact, several recent national reports, including the Surgeon General's Report on Mental Health (1999) have listed integrated treatment as a best practice or evidence-based practice (see Table 2). Assessing psychiatric severity for placement and treating co-occurring disorders with an integrated approach also has been recommended by CSAT (e.g. Ries, Mullen, & Cox, 1994), and the American Society of Addiction Medicine (1996). A recent survey by NASMHPD's Research Institute reported that 37 states are implementing or planning to implement integrated treatment for co-occurring disorders (2002).

Several Practice Guidelines for treating individuals with co-occurring disorders have been written by national groups and states (see Table 2). The Writing Team used these reports as examples. In Missouri, as in many other states, integrated treatment can be difficult to provide due to separate funding streams for mental health and substance use treatment. Thus, in addition to describing integrated treatment principles, systems issues are identified and recommendations are provided to assist both types of providers to more adequately treat these clients.



### III. General Principles for Integrated Treatment



### III. General Principles for Integrated Treatment

The following principles should guide definition and implementation of a system of care for persons with co-occurring disorders and are based on principles defined in the Center for Mental Health Services [CMHS], *Co-occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula*. Kenneth Minkoff & Anne Rossi (panel chair and co-chairs) (CMHS, 1998).

#### Welcoming Attitude

Individuals presenting for services with co-occurring disorders should be seen as an expectation for the system of care as opposed to an anomaly (Minkoff, 2001). “In traditional systems of care, people with co-occurring disorders often experience themselves as system misfits, unwelcome, unwanted, and blamed for the complexity of their difficulties” (CMHS, 1998). Therefore, in addition to having integrated programming, the system must expect and welcome consumers and families of consumers with co-occurring disorders. The following guidelines were developed for the CMHS report (1998):

- Intake staff are trained to work comfortably and empathically with individuals with co-occurring disorders.
- Co-occurring disorder consumers are welcomed through program literature, policies, procedures, and payment mechanisms.
- Mental health department policies state that agencies cannot discriminate against consumers with co-occurring disorders.
- A hopeful and optimistic recovery philosophy is defined and reinforced through staff and system training.
- Ongoing engagement of individuals with co-occurring disorders, even when they make no immediately discernible progress is supported by utilization management policies.

#### Accessibility (No Wrong Door)

A major challenge for people with co-occurring disorders is gaining access to the services they need (Owen et al., 1997). The system of care “must develop, in conjunction with consumers and families, a system of access that can accommodate people with co-occurring disorders no matter where or how they present” (CMHS, 1998). The following guidelines were developed for the CMHS report (1998):

- All system intake services may initiate assessments and complete dispositions on individuals with any combination of psychiatric and substance use disorder.
- Admission and assessment are initiated without regard to recent alcohol or drug use.
- Treatment may be initiated when neither disorder is at baseline; consequently, initial diagnoses are often presumptive, and the initial goal of assessment is to engage the individual in an ongoing process of continual re-

assessment as treatment progresses. Diagnosis may be revised as new data emerge.

- Information about co-occurring disorders is accessible to consumers and families in all service delivery settings through educational literature and psychoeducational interventions.
- Accessibility requires engaging consumers in various stages of treatment readiness. “Lack of motivation” is not a barrier to services; services are stage-appropriate. Staff demonstrate empathy, acceptance, and positive regard for consumers, regardless of readiness to change.
- The service system should not begin or end at the boundaries of formal treatment programs; rather, it includes interventions to engage the most detached individuals who may be alienated from helping systems or unable to recognize their disorders and ask for help effectively (e.g., Carey, 1996; Ziedonis & Trudeau, 1997).
- It is imperative that persons with co-occurring psychiatric and substance use disorders are provided access to effective medications for both disorders.
- Access to services is not denied if a person is continuing to use substances, is on a prescribed non-addictive psychotherapeutic medication, or is taking medication for a mental illness and is using substances.

### **Common Consumers Treated by both ADA & CPS**

When treatment is fragmented between two systems, the burden of solving problems between the systems is on the consumer and family. Thus, consumers can be deprived access to appropriate interventions. The following are guidelines for integrated treatment (CMHS, 1998):

- Consumers and families receive treatment for co-occurring disorders in the settings in which they receive treatment for their most serious disorder.
- Each disorder should receive phase-specific and appropriately intensive simultaneous treatment that takes into account the level of severity and engagement for each disorder.
- Each individual should have a primary relationship with an individual who coordinates ongoing treatment intervention for both disorders.
- Each individual should have access to clinicians or multidisciplinary teams who have expertise in both mental health and substance abuse treatment, as well as expertise regarding best practices in providing services for co-occurring disorders.
- Integrated treatment should be provided by the same clinicians or teams of clinicians, working in the same setting and providing both mental health and substance abuse interventions in a coordinated fashion.
- Family members and significant others of whom the individual approves are involved in the treatment planning and service delivery process.
- All mental health and substance abuse agencies provide outreach components for persons within the system for continuous engagement and follow-up.

- Providers are encouraged to use and are trained in Motivational Interviewing and other client-centered models (e.g., Miller & Rollnick, 1991).
- Ongoing and episodic interventions require consistent collaboration and coordination between all clinical staff, family caregivers, and external systems (Greenfield, Weiss, & Tohen, 1995).

### **Model for Continuum of Care**

For this population, outcomes are enhanced when consumers can develop ongoing, caring therapeutic relationships with cross-trained clinicians and/or integrated programs. The power for change and positive clinical outcomes is in the relationship. Thus, continuity of clinical responsibility needs to be maintained regardless of the consumer's point of entry into the system. The following guidelines are to maintain continuity of care (CMHS, 1998):

- The concept of appropriate level of care or treatment is emphasized, rather than labeling a move from one locus of treatment and support to another as a "failure."
- Consumers with co-occurring disorders are connected to a clinician or team who will maintain a long-term continuous therapeutic relationship that anticipates and expects fluctuations in the consumer's drug/alcohol abstinence or treatment compliance.
- The therapeutic relationship is initiated at the consumer's stage of readiness and permits progress at his/her pace without clinicians or teams imposing unrealistic criteria that may jeopardize the relationship (i.e., treatment is not terminated if the consumer relapses or does not become abstinent within a specific time frame).
- Welcoming, empathetic, hopeful, continuous treatment relationships are initiated that sustain integrated treatment and coordination through multiple treatment episodes.
- Within the Continuum of Care, shelter and housing are provided with varying levels of supervision, depending on the needs of the individual.

### **Cultural Competency**

Individuals with co-occurring disorders should receive culturally relevant care that addresses and respects language, customs, values, and morals and has the capacity to respond to the individual's unique family, culture, traditions, strengths and gender.

- Providers are located in ethnically defined neighborhoods.
- Providers can speak their clients' language.
- Accessible and understandable literature is available for diverse clients.
- Providers participate in cultural competency training.
- Access and utilization performance is measured among identifiable populations.
- Standards regarding cultural competency are included in the integrated treatment core competencies.

- Community-based service delivery agencies have culturally competent administrations.
- Interpreter services are available for clients who are hearing impaired or speak a different language.

### **Effectiveness**

Services for consumers dealing with co-occurring disorders should be outcome based as defined by the consumer and will provide evidence of effectiveness through the appropriate use of periodic outcome evaluations and consumer satisfaction assessments. Measures should include progress through treatment phases and multi-dimensional psychiatric, substance and functional outcomes.

## IV. A Model of Integrated Treatment



## IV. A Model of Integrated Treatment

### A. Outreach and Engagement

Many individuals living in the community who have co-occurring disorders are unwilling or unable to make an effort on their own to receive needed services. They may feel that they do not have a disorder, may not trust the service system due to prior experience, may not like available treatment options, or may not seek services for other reasons. Often these individuals' interface with the service system is via presentation at the emergency room, contact with a crisis system, contact with the criminal justice system, or involuntary or outpatient commitment. These are high cost, inefficient interventions that fail to keep the individual connected with the service system for the length of time necessary to address co-occurring disorders. In part, due to limited resources of the present service delivery system, the onus is on that individual to access the ongoing community services that he/she may need. For these reasons, outreach and engagement services need to be available and ways of paying for these services need to be explored.

Outreach is the process of identifying people living in the community who have co-occurring disorders and are either not currently receiving treatment services or have become disengaged from services.

- Many individuals with co-occurring disorders have problems both connecting with service providers and participating in traditional treatment programs (Owen et al., 1997).
- Clients are typically ambivalent about stopping substance use. Drugs produce at least some pleasant effects in addition to negative effects. Motivation changes from day to day or hour to hour, as the balance of positive and negative valences change (Kleber, 1989).
- Outreach services should identify individuals with co-occurring disorders who are homeless or disengaged from traditional access to treatment.
- Assertive outreach is a component of an effective program. Clients and their support systems are contacted and engaged through case management mechanisms, such as home visits (Mercer-McFadden, Drake, Brown, & Fox, 1997).
- Outreach can begin the process of building relationships with treatment providers and a consistent program that can decrease noncompliance and dropout (Hellerstein, Rosenthal, & Miner, 1995).

Engagement is the process of developing a trusting relationship between a provider and a person with co-occurring disorders and, through the power of that relationship, keeping the client engaged through the stages of change for both disorders. The following components of engagement are based on Ho et al. (1999) who found that after engagement in treatment, clients were more likely to receive medication services and training in relapse prevention skills.

- The service of engagement gives providers the capacity for *in vivo* contact in the post-outreach phase.

- Once the individual has been identified through outreach, engagement allows for the development of a relationship.
- Contacts are generally not initially based on the presenting disorder(s). Rather the contacts are based on human needs and one-on-one contact with the identified person, *as a person not a sick person*.
- In conjunction with integrated psychiatric care, assertive case management enhances the engagement process by maximizing clients' access to social and rehabilitative resources.

Engagement techniques are similar across combinations of co-occurring disorders, but differ based on the client's level of motivation (Drake et al., 2001).

- Pre-Motivational: Outreach, relationship building, collateral contacts, practical support, consideration of legal/coercive constraints and use when necessary.
- Motivational: Motivational interviewing, motivational enhancement therapy, engagement groups (individuals and families), harm reduction strategies, behavioral contracting, empathic confrontation with consequences, education regarding disease and recovery, social network intervention.

## **B. Assessment**

Assessment with consumers who have co-occurring disorders is a complex, continuing process. Several types of screening and assessment need to occur: all mental health treatment settings need to screen for substance use disorders; all substance abuse treatment settings need to screen for mental illness; and a comprehensive, integrated assessment needs to be conducted on any consumers who are thought to have co-occurring disorders based on such screenings. There are available reliable and valid instruments for each of these types of screening and assessment. However, an in-depth review of these instruments would be needed to garner recommendations for a set of common instruments that would meet the needs of providers in Missouri. The following are general principles of assessment and elements of a comprehensive assessment.

### Principles of Assessment

- Severe mental illness and substance use disorders are both primary disorders, each requiring specific and appropriate assessment.
- Severe mental illness and substance use disorders are both chronic, relapsing illnesses that can be conceptualized using a disease and recovery model.
- Persons with co-occurring disorders present in different stages of motivation or readiness to change with regard to either illness.
- A professional and/or multidisciplinary team with expertise in both mental health and substance abuse should assess consumers with co-occurring disorders.
- The individual is encouraged to include family members, significant others, and service providers in the assessment process.



- Assessment is an individualized and continuous process. Engagement of the client in the treatment process begins in the initial screening/assessment interview. Motivational interviewing/enhancement techniques are useful in overcoming resistance.
- Due to the changing nature of both disorders, as well as difficulty with gaining accurate diagnoses at times, a full assessment must be repeated at least once per year.

### Key Elements of a Comprehensive Assessment

These elements may be obtained through a combination of screening/assessment instruments, laboratory tests, collateral interviews, clinical record review, and interview. Written permission must be requested from a client to access and review medical, mental health, and substance abuse treatment records, legal records, employer, and family contacts.

1. Demographic Information
2. Medical History
  - Medications (current/past) including potential abuse/misuse, side effects, prescribing physician information, adherence, withdrawal, etc.
  - All past/current medical conditions
  - Women: Pregnancy and plans to become pregnant, reproductive health history and outcomes
  - High risk behavior(s) that may impact possibility of infectious disease(s)
  - Current physician contact information
  - Family history of medical problems
  - How person/family/significant others define and perceive medical condition(s)
3. Alcohol and Drug Use History
  - Use of alcohol/other drugs (legal and illegal)
  - Mode of drug use
  - Quantity/frequency/pattern of use
  - Alcohol/drug/prescription combinations
  - Legal history related to alcohol/drugs including consequences
  - Craving (dreams, thoughts, desires, physical urges)
  - Family history of alcohol/drug use
  - Attempts to limit and/or control use of substances
  - Treatment history including where, when, and outcome
  - How person/family/significant others define and perceive alcohol/drug use including willingness to participate in treatment
4. Mental Health History
  - Assessment for all diagnoses
  - Treatment history including where, when, and outcome
  - Psychotherapeutic medication history, adherence, side effects, attitude regarding use of medication
  - Family history of mental health disorders

- Risk of dangerousness, level of functioning (past/present), severity of current symptoms
- 5. Family/Social/Legal History
  - Marital status/parenting status
  - Legal status
  - Cultural/ethnic background including language, values, traditions, gender role
  - Religious affiliation, spiritual beliefs
  - Relationship with family/friends/partner/employer including parenting issues
  - Trauma history as perpetrator and victim including domestic violence, child abuse, other abuse (physical, emotional, verbal, sexual), other trauma
  - Educational level
  - Occupation/work history including interruptions in history
  - Legal history including current status/arrest/citations
  - How person/family/significant others define and perceive family/social/legal history
- 6. Sexual History
  - Sexual preference
  - Relationship history and current sexual activity
  - Sexual disorders and dysfunction (interest, performance, satisfaction)
  - Use of safe sex practices/birth control

## C. Treatment

### Integration

Addiction and psychiatric services need to be integrated on a variety of levels:

- Structural integration from an organizational perspective
- Service delivery level integration
- Clinical staff are cross-trained and/or on multidisciplinary teams
- Integration of acute care facilities and more long term community support resources such that professionals operating in these environments are aware of the others
- Integration with external systems that are part of the more comprehensive service delivery environment, including services involving children, adolescents and families, and correctional facilities, rehabilitation services and housing services

### Program Components—Continuum of Care

Ideally, an integrated service system would address the whole continuum of care. Such a service delivery system capable of providing effective treatment to individuals with co-occurring disorders should include the following program elements outlined in the CMHS report (1998):

### Emergency Triage Crisis Services

- Emergency services with co-occurring disorders capacity provide twenty-four hour availability for crisis assessment of clients
- All clients receive an integrated assessment of substance use disorders and psychiatric symptoms to determine the most appropriate service intensities that address the need for crisis stabilization
- Services offer brief crisis intervention, including follow up crisis visits, psychopharmacology assessment, and family crisis intervention
- Referral to ongoing, intensive outpatient services, including outpatient detoxification, is available

### Crisis Stabilization Beds

- Short term, non-hospital residential services that provide emergency intervention to clients in crisis
- Accommodate clients in psychiatric crisis and/or who are intoxicated
- Program content includes twenty-four hour staffing with available nursing and psychiatric consultation
- The goals of treatment are to safely stabilize the acute crisis and encourage appropriate follow-up in ongoing psychiatric and substance abuse treatment

### Detoxification Services

- Provide supervised detoxification for substance dependent individuals while maintaining psychiatric stabilization
- Refer to appropriate ongoing treatment for both disorders

### Inpatient Psychiatric Treatment

- Provide hospital level care to clients who require the most intensive levels of supervision
- The goals are to provide clients with rapid and accurate identification of mental illness and substance abuse disorders, stabilization of both psychiatric and substance abuse symptoms, and engagement to accept appropriate referrals for ongoing treatment
- Assessment procedures comprehensively address mental illness and substance use disorders
- Group programming includes addressing substance-related issues daily
- Discharge planning staff are familiar with co-occurring disorders resources
- Clients receive psychopharmacologic monitoring and medication adjustment, individual and group counseling and education, occupational therapy, family education and counseling, and program based case management
- Staff are cross-trained with competency for mental illness and substance abuse rehabilitation

### Residential Substance Abuse Treatment

- Residential rehabilitation treatment that can accommodate clients whose severe mental illness is not stable
- Assessment procedures comprehensively address mental illness and substance use disorders
- Clients receive psychopharmacologic monitoring and medication adjustment, individual and group counseling and education, occupational therapy, family education and counseling, and program based case management
- Program content may vary, but should include individual and group treatment that is stage-based, non-confrontational, and addresses relapse prevention.
- Staff are cross-trained with competency for mental illness and substance abuse rehabilitation

### Day Treatment/Intensive Outpatient

- This category encompasses acute, subacute and long-term programs, which provide structured outpatient interventions for co-occurring disorders
- Interventions may include partial hospitalization, psychiatrically enhanced addiction day treatment, intermediate co-occurring disorders rehabilitation (1-3 months), and long-term co-occurring disorders day treatment in which premotivational clients receive intensive motivational interviewing
- Program content may vary but should include cross-trained multidisciplinary staff, integrated assessment, treatment planning and case management, coordination with outside care givers, psychopharmacologic monitoring, individual and group treatment, and a dual recovery philosophy

### Intensive Integrated Case Management

- Flexible, client centered interventions that engage clients at any stage of readiness and whenever they present
- Services characterized by mobility, outreach, continuity and provision of non-traditional services
- Provided by individual clinicians or multidisciplinary teams
- The treatment model includes specific interventions described in the literature, including continuous treatment teams, assertive continuity treatment teams, and the PACT model
- Case management teams develop shared competencies across multiple areas of expertise
- Programs provide integrated assessment, diagnosis, and treatment planning
- Crisis intervention and individual group and family counseling are also available

### Outpatient

- Provide integrated assessment, treatment planning and ongoing treatment.
- Program content includes dual competencies staff, multidisciplinary treatment planning, individual and group psychotherapy services, and psychopharmacology evaluation and management.

### Residential Services

- Although residential services are not usually reimbursed under managed Medicaid, they are essential to treatment success and reduced utilization of expensive acute services
- Models may include traditional group homes, case managed supportive housing, modified therapeutic communities, and psychiatrically supported shelters
- Residential services should be categorized according to level of psychiatric disability and substance use expectation
- “Dry” housing requires abstinence; residents will be asked to leave after a number of lapses
- “Damp” housing encourages, but does not require abstinence, but does require moderation and will exclude residents who are disruptive
- Staff competency must match the level of disability of the residents
- Program content may include some groups, individualized counseling, case management, social and vocational rehabilitation, leisure skills training, living skills training, money management, and close monitoring

## D. Pharmacological treatment

Co-occurrence of substance abuse and psychiatric disorders is common. Although there is a large body of research regarding use of psychopharmacologic agents for mental illness, and a growing body of research regarding use of psychopharmacologic agents for substance dependence, there is limited research specifically regarding medication in clients with co-occurring disorders. This does not suggest that psychopharmacologic agents should not be used, rather that there are some special considerations and care that need to be taken when assessing these clients for medication and designing a medication regimen. Expert consensus suggests that many front-line providers of either mental health or substance abuse treatment are not necessarily well-informed regarding use of medications in clients with co-occurring disorders, and that there is some level of misinformation. However, medication may be necessary to safely detox patients, and to stabilize psychiatric disorders acutely and over a chronic course.

Assessment of the need for medication should occur as early as possible in the course of treatment

- *Initial treatment should be symptom focused, not diagnosis focused.* It may take time to establish the most correct diagnosis; therefore, treatment should proceed first, and when symptoms abate then the focus may shift to diagnosis.
- Establish medical and psychiatric safety, recognizing the potential need for acute inpatient management to stabilize psychotic disorders (Beeder & Millman, 1997; Kasser, Geller, Howell, & Wartenberg, 1998).
- Utilize antipsychotics, benzodiazepines, and other sedatives to control dangerous or threatening behavior (Yudofsky, Silver, & Hales, 2001).
- In acute withdrawal requiring medical detox, use standard detox methods according to the same protocols as used for clients with addiction only. Untreated alcohol, barbiturate and benzodiazepine acute withdrawal may result in seizures, delirium tremens, or death; therefore, management of these withdrawal syndromes should receive highest priority (CSAT, 1995).
- Existing non-addictive psychotropic medication should be continued during detox and stabilization (CSAT, 1995, 1999; Ziedonis & Wyatt, 1998).
- Assessment of previous periods of abstinence, a careful longitudinal history of substance use patterns, and information from family and support providers should be collected to assist in differential diagnosis.

Establish a medication treatment plan for severe mental illness

- Ideally, diagnostic and treatment decisions regarding mental illness should be made when substance abuse is in remission; likewise, management of substance use disorders is facilitated when mental illness is stabilized. Nevertheless, these ideal circumstances are frequently not feasible, and *use of psychotropic medications does not require that the client be abstinent.*
- Psychopharmacologic agents without addictive potential are indicated for clients who have severe mental illnesses that are usually treated with medications in the absence of comorbid substance use. Decisions about when to initiate psychotropic medications should not be based on an arbitrary timepoint (i.e., 30 days abstinence) and must be individualized for the client and the psychotropic medication. Once an efficacious psychotropic medication has been established, it should be continued even if relapse to substance use occurs (Beeder & Millman, 1997; Brady, Halligan, & Malcolm, 1999; CSAT, 1999; Ziedonis & Wyatt, 1998).
- Standard psychopharmacology practices should be employed and effective agents should be used in adequate dosages. Monitoring blood levels of certain medications, such as anticonvulsants, is important because of metabolic interactions with numerous substances (Mason, 1996).
- Non-addicting psychotropic medications should not be withheld during periods of drug and/or alcohol use unless potential interactions with licit or illicit drugs are life-threatening. Atypical antipsychotics appear to be useful for psychotic

symptoms and may reduce craving for stimulant drugs (CSAT, 1999; Volavka, 1999; Ziedonis & Wyatt, 1998).

Careful attention should be given to clients' ability to adhere to prescribed medication because of the cognitive impairments associated with comorbid substance use

- Oral and written instructions must be provided. The client must understand the necessity of daily, continuous medication use, and a resource should be provided for questions prior to next medication evaluation.
- *Clients should be explicitly told that their medications (except benzodiazepines and stimulants) are not dangerous in combination with drugs of abuse and that they should continue them even in the event of a lapse or relapse.*
- Mechanical and reminder assistance should be provided to facilitate medication adherence. These may include written schedules and pill boxes that are set up and maintained under weekly/bimonthly supervision. Scheduling medication dose should be simple and convenient, preferably once daily. Use of injectable depot medications may be helpful, when available.
- Side effects of medication must be closely monitored as adherence may be limited if side effects are troublesome. The client should be offered strategies to reduce the impact of side effects on lifestyle, especially in regard to sexual activities, weight gain, and sedation.
- Education must be provided for the patient and family in preparation for peer reaction to the use of medication when participating in Twelve-Step programs, which sometimes have a negative attitude toward medication use.

Use of medication to facilitate sobriety

- Anti-craving medication such as naltrexone or acamprosate should be presented as complementary to a full recovery program (Oslin et al., 1999; Swift, 1999, for review).
- Use of psychotropic medications to manage symptoms of mental illness and reduce craving may facilitate engagement in treatment and reduce preoccupation with abused substances (Carroll, Nich, & Rounsaville, 1995; Cornelius et al., 1997, 1999; Drake, Xie, McHugo, & Green, 2000; Hertzman, 2000; Kranzler et al., 1995; Levin et al., 1998; McDowell, Levin, Seracini, & Nunes, 2000; McGrath, Nunes, Stewart, Goldman, & Agosti, 1996; Nunes et al., 1998; Zimmet, Strous, Burgess, Kohnstamm, & Green, 2000).
- Use of addictive psychotropic medications should be avoided beyond the withdrawal period. Patients with substance dependence disorders who have documented benefits and no evidence of misuse of agents such as benzodiazepines may be continued with close monitoring. Detailed discussion with the client and family should document risks and conditions of continuing prescription. Clients with remitted substance dependence disorders who present with an established regimen of addictive psychotropic agents may be

continued with an agreement that receiving such medication is dependent on continuing abstinence (Mueller, Goldenberg, Gordon, Keller, & Warshaw, 1996).

- There is a paucity of research addressing use of opiate substitution for patients with comorbid major psychiatric disorders, and patients with schizophrenia or bipolar disorder are infrequently enrolled in opiate substitution programs. However, there is no evidence to suggest poor response to methadone or adverse interactions of psychotropic agents with opiate agonists (King & Brooner, 1999). The efficacy of opiate substitution is well-known and should be considered in selecting treatment for patients with opiate dependence disorders and comorbid psychiatric disorders. Clients who are in opiate substitution programs need to be evaluated and managed by a specialist at least until major recovery is reached.

## **E. Consumer/Family Oriented Issues**

### **1. Customer-Focused/Consumer-Family Centered Practice Standards**

The following are standards specific to consumers and families, and follow the General Principles for Integrated Treatment outlined earlier (based on CMHS, 1998).

#### Welcoming Attitude

- All individuals with co-occurring disorders and their families are treated with encouragement, understanding, and respect.
- All staff shall be knowledgeable about co-occurring disorders and appropriate treatment methods.
- Under no circumstances are individuals with co-occurring disorders discriminated against.
- “People with co-occurring disorders - and their families - are empowered to make treatment decisions, but not abandoned for making the wrong choice; they are protected whenever possible from immediate harm to self or others, but not indefinitely restricted, controlled, or punished” (CMHS, 1998).

#### Accessibility of Services

- Individuals begin to participate in assessment upon entry into services, regardless of their current presentation.
- Assessments are comprehensive to address individuals with co-occurring disorders, especially given that one disorder may not be the most prevalent at the time of initial assessment.
- Consumers have access to services that encompass a full range of stages of treatment readiness, and an established set of guidelines is used for placing consumers in the most appropriate treatment setting.
- Detoxification is available for acute stabilization, and necessary referrals are made for individuals requiring a higher level of treatment, as determined by assessment.



- Individuals and their family members have direct access to information on mental illness and substance abuse disorders, along with consultation by a trained staff member.

### Integration

- Consumers access treatment for both mental illness and substance abuse in the least restrictive environment they require that addresses the disorder that is most prevalent.
- Professionals trained in both disorders administer competent care.
- “All programs within the system are required to provide integrated services to consumers and to specify - accordingly to subtype of dual disorder and phase of treatment - the type(s) of integration offered” (CMHS, 1998).
- Mental health and substance abuse services are integrated with community agencies and referral sources to enhance the benefits for consumer and their families in daily life skills.

### Continuity of Care

- Consumers are placed with a primary service provider(s) for the duration of services so that a therapeutic relationship is fostered.
- Consumers are not forced through a program and advance only through their own level of motivation and readiness, and suffer no consequences for stagnation.
- In crisis situations, in-home services are available if requested.
- “With acute episodes, continuity of clinical responsibility is maintained throughout the episode even if the consumer moves between levels of acute care (e.g. hospital-crisis bed-day hospital)” (CMHS, 1998).
- Family members are encouraged to establish a connection with the primary service provider(s) for the duration of illness.
- Services remain active even when the consumer enters a recovery support group, recovery home or other residential support.

### Comprehensiveness

- All services encompass and accommodate differences in gender, race, ethnicity, culture, language, sexual orientation, etc. in a sensitive manner.
- Assessment is comprehensive and identifies early signs/symptoms of mental illness and substance abuse.
- Consumers and their families are assisted in acquiring independent living skills, community services, and education to promote a successful recovery network.
- Creative variations in service structure are available and utilized in individual sessions, peer groups, skills training, and home-based sessions.

- Consumers have opportunities to engage in continued treatment within the system of the treatment provider, with the stipulation that this continues to be the appropriate service.
- “Each consumer requires dual diagnosis treatment services that are individually matched, based on the specific subtype of dual disorder, specific diagnoses, and the acuity, severity, disability, treatment readiness, and phase of treatment for each disorder” (CMHS, 1998).

## 2. Consumer/Family Involvement

### Consumer/Family Involvement in Quality Management

- Input from consumers and families is an integral part of delivering quality services and changing ineffective services to maintain quality care.
- Involving consumers/families in program planning, and assessing the effectiveness and satisfaction with services, provides data on the strengths and weaknesses of a program.
- Consumers and families collaborate with the treatment team to make informed decisions concerning treatment options and goals.

### Consumer/Family Involvement in Service Delivery

- Participation in community peer support is encouraged for consumers and families to be involved in a continued recovery program with others who have co-occurring disorders.
- “Consumers have access to peer treaters, case managers, and counselors; there is a process for training, credentialing, and reimbursing peer counselors for dual diagnosis consumers and families” (CMHS, 1998).
- Supported residential programs and crisis lines can be consumer operated and should receive participation encouragement from primary service providers.

## F. Special Groups

### 1. Criminal Justice System

As funding for community based mental health and substance abuse treatment services and availability of inpatient services have declined over the past decade, there has been an increase in individuals with both mental illness and substance use disorders entering the criminal justice system. It is estimated that approximately 13 percent of the prison population have co-occurring mental illness and substance abuse disorders (US Department of Justice, 1996). Increased rates of inmates with co-occurring disorders may be related to:

- Mandatory sentencing laws relating to crimes involving illicit substances
- Stigma and fear associated with mental illness and substance use disorders

- A decline in resources and availability of inpatient and outpatient treatment services

Jails are ill equipped to handle the special needs of this population, and most correctional officers are not trained to adequately manage this high risk group of inmates. Recommendations from Oregon's Statewide Task Force on Dual Diagnosis (2000) include:

- Train law enforcement, corrections, and parole and probation officers in identifying and dealing with persons with co-occurring disorders
- Screen everyone entering the criminal justice system for co-occurring disorders through the usual initial screening and evaluation system
- Use jail diversion programs (including Drug and Mental Health Courts) for persons with co-occurring disorders to get them into appropriate treatment programs. Effective jail diversion programs need to include the following:
  - Integration of all services at the community level: corrections, courts, mental health providers, substance abuse treatment providers, and social service agencies (assisting with housing and entitlements)
  - Use of liaisons or "boundary spanners" who have the trust of key stakeholders from each system and can bridge barriers and manage interactions between corrections, mental health, and judicial staff (National GAINS Center, 1997)
  - Identification of a leader with good communication skills, and an understanding of the systems and informal networks involved whose sole responsibility is to develop a diversion program (National GAINS Center, 1997)

State and Federal Prisons have recently developed dual diagnosis programs that are based on existing substance abuse treatment programs and approaches. In a review of seven such programs, key program elements included: an extended assessment period, orientation/motivational activities, psychoeducational groups, cognitive-behavioral interventions such as restructuring of criminal thinking errors, self-help groups, medication monitoring, relapse prevention, and transition into institution or community-based aftercare facilities. Many programs use therapeutic community approaches that are modified to provide (a) greater individual counseling and support, (b) less confrontation, (c) smaller staff caseloads, and (d) cross-training of staff. Research is currently underway in three of the seven sites to examine the effectiveness of these new programs. (Edens, Peters, & Hills, 1997)

## 2. Rural needs

Rural areas are highly diverse in terms of culture, ethnicity, and economics (Conger, 1997; Sawyer & Beeson, 1998). However, one common theme is that people in rural areas must deal with co-occurring disorders where service resources are limited compared to those available to their urban counterparts (Sawyer & Beeson, 1998; Hendryx, Borders, & Johnson, 1995). Limited availability, accessibility, and acceptability of rural mental health services create serious consequences for individuals and families (Human & Wasem, 1991). In particular, rural women seeking

substance abuse and/or mental health treatment encounter a variety of barriers including inability to pay, lack of transportation, unsafe and inadequate housing, and child care needs (Tatum, 1994). Cultural barriers include a mistrust of outsiders, fatalistic life attitudes, and a tradition of self-sufficiency (Tatum, 1994).

The following are recommendations for providing services to consumers with co-occurring disorders in rural areas (Laarson, Beeson, & Mohatt, 1993; Sawyer & Beeson, 1998):

- Involve consumer and family members
- Community based, integrated services
- Adoption of empowerment rehabilitation models
- Inter-agency collaboration
- Cultural competence

Because there is limited acceptability of mental health services within rural areas, service providers need to be sensitive to confidentiality issues. It is likely that many community members know who the service providers are and where they are located. Individuals observed talking with providers or on the provider's premises will be identified as receiving services. Also, because occupational, social, school and church relationships overlap in rural communities dual relationships will often test confidentiality and boundary issues.

### 3. Trauma

Numerous studies have demonstrated the pervasive and disabling effects of trauma, which includes sexual, physical, and emotional/psychological abuse. Individuals with co-occurring disorders have higher rates of trauma than those without (e.g., CSAT, 2000; Tatum, 1994; Heise, Ellsberg, & Gottemoeller, 1999). Likewise, those who have experienced trauma have higher rates of substance use and mental illness (Goodwin, Cheeves, & Connell, 1988; Root, 1989). Unresolved trauma can contribute to relapse, as individuals may return to substance use to cope with unresolved effects of trauma (Hagan, Finnegan, & Nelson-Zlupko, 1994; Harris, 1996).

Individuals with co-occurring disorders and a history of trauma have unique treatment needs. These include more intensive services, longer lengths of stay in treatment, and addressing their potential for self-injurious behaviors or homelessness (CSAT, 2000; Goodwin, 1995; Harris, 1994; Scallet, 1996).

Integrated treatment is the treatment of choice for individuals with co-occurring disorders who have experienced trauma (e.g., Alexander & Muenzenmaier, 1998; Brown, 1997). In their 1998 report, *Responding to the Behavioral Healthcare Issues of Persons with Histories of Physical and Sexual Abuse*, NASMHPD and CSAT recommended: "in a era of limited resources, service system integration and collaboration are the keys to accessing services for people with multiple problems. An integrated system should be seamless so individuals can address trauma no matter where they seek that help." The report identifies specific actions to promote

collaboration, including raising awareness of trauma and support for cross-agency interventions that focus on empowerment and recovery.

#### 4. Clients with infectious diseases (e.g., HIV/AIDS, Hepatitis, TB, STDs)

Infectious diseases are common among drug users. Individuals who enter treatment programs are at risk of having one or more of the following diseases: HIV/AIDS, tuberculosis, syphilis and other STDs, and hepatitis (A, B, C, D, E, and G). People are becoming infected with Hepatitis B and C at an alarming rate. “There are about 1.2 million people in the U.S. with hepatitis B and about 4.8 million people (1.8% of the U.S. population) with hepatitis C” (Centers for Disease Control and Prevention, 1997). Eight out of ten people with hepatitis C will develop a chronic infection (American Liver Foundation, 1996, 2001).

Treatment staff must be knowledgeable about infectious disease risk factors, screening procedures and the impact such diseases may have on the course of substance abuse treatment. Staff must be knowledgeable about and sensitive to treatments for infectious diseases, including their side effects and impact on psychological medications. Infected individuals may need medical care, psychosocial services and other resources; providers must be prepared to access a range of community-based services on behalf of their clients.

The following areas should form the basis of a comprehensive risk assessment:

- Use of needles
- Snorting drugs with the same instrument as others
- Tattoos or body piercing
- Blood transfusions before 1992, including blood received during a c-section
- Employed in healthcare or exposure to blood in the military
- Sharing a razor, toothbrush, or any item that could carry blood
- History of unprotected sex or sexual activity at a young age
- Exposure to anyone with active tuberculosis, including sharing drinks or cigarettes
- History of testing for tuberculosis and other infectious diseases

#### 5. Parents with co-occurring disorders

##### Pregnant Women with Co-occurring Disorders

Children exposed to drugs in utero are at risk for developmental and other problems (Wetherington, Smeriglio, & Finnegan, 1996). Early intervention during the prenatal period is highly desirable for the health of the woman, the fetus and the infant after birth and for the initiation of substance abuse treatment. Services must not be denied solely because a woman is pregnant. The Treatment Improvement Protocol (TIP # 2) for Pregnant, Substance-Abusing Women developed by CSAT (1995) suggests the following as necessary treatment components:

- Sensitivity of treatment providers to women's feelings and the cultural background
- A treatment environment that is supportive, nurturing, and non-judgmental
- Access to comprehensive medical care
- A continuum of care including collaboration and cooperation of community-based services: safe housing, parenting education, domestic violence services.
- Case management services to ensure that a comprehensive and optimal level of care is available and accessible

### Children of Parents with Co-occurring Disorders

Parental substance abuse causes or exacerbates 7 out of 10 cases of child abuse or neglect, and children with substance abusing parents are almost 3 times more likely to be abused and more than 4 times more likely to be neglected (National Center on Addiction and Substance Abuse at Columbia University, 1999). The children of substance-abusing parents also face an increased risk of developing a substance use disorder themselves.

The recommended strategy for dealing with substance abusing parents and their children is to integrate intensive early childhood and family-focused services in treatment settings, including:

- Help with parenting skills
- Provision of developmentally appropriate childcare
- Access to on-going health care
- Therapeutic interventions for the children

## V. Agency and Provider Competencies



## V. Agency and Provider Competencies

Staff training in substance abuse and mental illness assessment and treatment includes a) attitudes, b) values, c) knowledge, and d) skills. All state-funded agencies should address co-occurring disorders to establish a “no wrong door” for clients. Regardless of level of training, clinical background, or service setting, the goals of providers are to facilitate the implementation of a welcoming service system, and foster the initiation and continuation of emphatic, hopeful, and empowering clinical relationships to promote recovery. The following competencies are based on several other guidelines and reports (e.g., Connecticut, 2002; Minkoff, 2000 [for Arizona]; Oregon Department of Human Services, 200) including the CMHS report (1998) that developed a full set of competencies and standards for training.

### Specific Attitudes and Values

- Compassion, empathy, respect, flexibility and hope to all clients, regardless of their degree or stage of recovery or level of cooperation/motivation
- Appreciation of diversity among individuals with different disorders, characteristics, and cultural backgrounds
- Willingness to become conscious of and manage personal biases to maintain a non-judgmental demeanor and approach
- Capacity to include and welcome family members and other service providers as collaborators
- Willingness to listen to, consider, and validate client’s perspective on problems and the solutions to those problems
- Acceptance of one’s inability to control another’s behavior
- Understanding of the holistic (social, emotional, physical, and/or spiritual) issues facing an individual with a co-occurring disorder
- Ability to communicate clearly and concisely, both verbally and in writing, in a manner respecting the dignity, integrity, and honesty of all

### Specific Knowledge-Based Skills

- Familiarity with the current edition of the DSM including diagnostic criteria for substance-related disorders (i.e., substance use, abuse, and dependence), other Axis I disorders (psychotic, affective, and anxiety), and Axis II personality disorders.
- Understanding of the pharmacological aspects of mental illness and substance use disorders including withdrawal symptoms, major substances of abuse, and medications used to treat mental illness and substance use disorders. Ability to recognize high-risk side effects, drug interactions, basic medical complications, and appropriateness/availability of pharmacological treatment.
- Familiarity with integrated models of assessment, intervention, and recovery for persons with co-occurring disorders.



- Knowledge of legalities (statutory and regulatory) related to each disorder and the treatment setting including privacy and confidentiality guidelines.
- Capacity and willingness to educate clients, family members, and other service providers about specific disorders and useful means of managing them.
- Knowledge that relapse is not a failure, but an opportunity to learn from experience.
- Knowledge of entitlement programs, support services, natural supports, peer support, and empowerment groups.
- Ability to use comprehensive, integrated and longitudinal assessment data for treatment planning, incorporating information from significant others including family members and service providers. Knowledge, use, and application of the biopsychosocial model, including a spiritual component. Ability to assess level of dangerousness including risk for suicide and violence and act appropriately upon the assessment data. Working knowledge of common medical concerns including but not limited to infectious diseases, TBI, pregnancy and geriatric concerns.
- Ability to collaboratively develop and implement an integrated treatment plan based on assessment that addresses all disorders and established goals considering level of motivation/engagement/stage of recovery. Solicit family/collateral input in determining treatment needs. Facilitate placement in least restrictive level of care.
- Familiarity with, and use of effective substance abuse treatments, including motivational enhancement, behavioral contracting, and cognitive-behavioral approaches to treatment and relapse prevention, skills and social skills training, psychoeducational, individual and group approaches, and interventions to treat persons with traumatic histories.
- Understanding of issues facing family members of persons with co-occurring disorders.
- Willingness to learn approaches for various stages of recovery, cognitive abilities, and combinations of co-occurring disorders.
- Familiarity with integrated, continuous case management and community treatment teams (i.e., PACT/ACT Teams) for persons needing such support.
- Skills to appropriately document information to meet legal requirements and facilitate effective treatment. Protect client's rights and confidentiality by adhering to laws governing the release of treatment information between service organizations.
- Awareness and willingness to seek on-going consultation and clinical supervision. Seek new learning opportunities, integrate new learning into practice, remain current in best practice models, work cooperatively and collaboratively as a treatment team member, and accept consultation and feedback to improve skills.

## VI. Model programs in Missouri



## **VI. Model programs in Missouri**

Within Missouri, at least two model programs represent an integration of treatment for substance abuse and mental illness. These programs have been designed within agencies that receive funding from both ADA and CPS. They have found ways to “braid” the funding streams and solve accounting and record-keeping practices between the two areas to provide programs that approximate the kind of integrated treatment model found most effective in the literature.

### **A. Family Counseling Center, Inc., New Beginnings Program, Kennett, Missouri**

The New Beginnings Program provides integrated treatment to persons with co-occurring mental illness and substance use disorders. The program incorporates elements of the Community Psychiatric Rehabilitation Center (CPRC) model and the Comprehensive Substance Treatment and Rehabilitation (CSTAR) model. A team with experience and training in both mental illness and substance use disorders provides treatment in a community-based environment to assist clients in maximizing independent living skills.

#### Program Overview

New Beginnings establishes a continuum of care with three time-limited levels of non-residential services designed to provide varying amounts of structure and types of services. The length and intensity of services and supports provided are individualized based upon needs identified during intake screening and the comprehensive assessment process. From the onset, clients are encouraged to actively participate and often sit in with the team during the initial treatment planning session. Clients may enter at any level - as determined by need. Assignment to treatment levels is based upon the current severity of the substance use/psychiatric issues and the available support system. Rehabilitation efforts utilize a strengths-based approach, focusing on the client’s skills, attitudes and behaviors. The primary goals are to assist the client in achieving and maintaining recovery while improving overall social functioning and quality of life. Key to this concept is the treatment team continually striving to envision such concepts as “quality of life” from the client’s viewpoint, not the team’s. Client independence and involvement in productive meaningful activity is strongly encouraged, emphasizing the physical, mental, emotional and spiritual needs as identified by each client aided by the treatment team.

#### Program Components

- Intake Screening
- Comprehensive Assessment
- Day Treatment
- Individualized Therapy
- Group Education
- Group Counseling
- Community Support Services
- Family Therapy
- Psychosocial Rehabilitation
- Crisis Intervention
- Medication Services
- Relapse Prevention

### Program Eligibility

Program eligibility is based upon standards set by Family Counseling Center and the Missouri DMH, through which the program is funded and certified. No one is refused treatment due to inability to pay.

### Barriers and Challenges

Although the New Beginnings program has made strides toward integrating services and supports to assist persons with co-occurring substance use and mental illness, the efforts have taken place within a system that as yet allows limited flexibility. As we work to address the many challenges faced by our clients, as practitioners and administrators we continue to deal with existing policies and regulations designed for single and separate systems of care. A key example can be seen with the lengths of stay authorized under the current CSTAR model that does not have a mechanism to allow for the complicated treatment issues facing our co-occurring population. Not surprisingly, our clients often fail and then are labeled “treatment resistant.”

Ultimately, the cost of treatment is greater because the initial lack of appropriate and timely services results in the “revolving door” process whereby more severe clients tend to use a disproportionate amount of the treatment dollars. Results from a recent comparison of client treatment costs when enrolled in the dual diagnosis program versus the prior monthly cost of separate treatment suggests that it only costs an average of \$340 more per client to be treated in the dual program. Another significant barrier is the minimal amount of staff that have been cross-trained for both substance use and mental illness treatment. Ultimate integration of our programs to provide effective treatment requires serious commitment to cross-train both mental illness and substance use providers.

### **B. University Behavioral Health Services, OASIS Program, Columbia, Missouri**

OASIS is committed to providing comprehensive, integrated treatment to people with co-occurring mental health and substance use disorders, maximizing each person’s potential for a stable productive life.

### Guiding Principles

- OASIS is based on the fundamental belief that co-occurring mental and substance use disorders are interrelated and that treatment should be integrated. The specially trained treatment team provides mental health services and substance abuse treatment in the same setting, at the same time, with a single treatment plan.
- OASIS encourages participants to use their personal power to change their lives. They emphasize the individual’s responsibility to make changes, and, along with natural supports, be actively involved in the treatment process. Staff provide a flexible level of support as needed to promote recovery, independence and community integration.

- OASIS recognizes the lifelong process of Recovery and is committed to designing treatment interventions to fit participants in different stages of the process and levels of motivation.
- Assertive outreach by peers and staff is an essential element in reaching those who are struggling with engagement in treatment.
- OASIS acknowledges the importance of optimism and recognizes that people with co-occurring disorders often become discouraged and hopeless. They maintain a hopeful welcoming attitude toward all participants, accepting relapse and setbacks as a natural and inevitable part of the recovery process.

### Program Overview

Psychiatric Rehabilitation and Substance Abuse Treatment are provided by a single treatment team with experience and training in both mental illness and addiction treatment. This provides the capacity to effectively deliver integrated assessment and treatment, and assures easy access to all levels of care needed to maximize the client's ability to function independently.

Clinical supervision to all team members is provided by a single supervisor with dual qualifications and experience. Integrating the supervision facilitates the treatment of a single co-occurring disorder rather than two separate disorders. This reinforces the clinician's ability to view the whole person and treat one co-occurring disorder and prevent the client from having a fragmented experience.

Each client is individually assessed to identify the interaction of the symptomatology of both disorders and the interplay between the two that fuels functional impairment in life areas. Particular attention is given to readiness to address disorders and a motivational approach is applied over time that is appropriate to the person's stage of development.

An individualized treatment plan is developed for each participant utilizing a menu of services including: intensive community support, individual and family counseling, group education and counseling, psychiatric and medication services, psychosocial rehabilitation, assertive outreach and crisis intervention. Each person's treatment progress is reviewed in interdisciplinary staff meetings to develop on-going interventions.

Involvement in twelve step groups is an essential element of the program. Participants are educated about the steps and traditions in group and individual sessions by staff in recovery. Involvement in peer supported Dual Recovery meetings is encouraged, as is attendance at community twelve step meetings.

Developing skills and strategies for Relapse Prevention is a theme that runs throughout the program with a focus on experiential learning. Participants learn to

develop personalized interventions that are incorporated into an in-home relapse prevention plan monitored closely by staff.

#### Program Components

*Intensive Community Support.* This is a community-based service designed to assist participants with skill development through hands-on assistance and problem solving. Target areas include: symptom management, housing and independent living skills, developing support systems, leisure, productivity and supported employment. Assessment of medication compliance and close monitoring of psychiatric symptoms are important elements. Providing feedback and assisting in the application of the relapse prevention plan is done by the case manager.

*Counseling.* Individual and Group Counseling are used to enhance a participant's awareness of the impact that substance use has on his/her life and enhance his/her desire to address these issues. Associations between the use of substances and mental stability are explored and articulated with the person. Resolution of identified problems and feelings around having a co-occurring disorder are addressed, as are strategic problem solving and relapse prevention.

*Assertive Outreach.* This intervention is designed to reach out to persons struggling to engage or re-engage in treatment. It involves going into the community, finding the person, and engaging them in a conversation that offers encouragement and motivation. It is expected to be a gradual process and is done by different members of the treatment team including peer supports, the case manager, counselor, crisis worker and medication provider.

*Medication Services.* Individual appointments are provided with a psychiatrist or Advanced Practice Nurse for medications. Medication administration of injectable psychiatric medications is available. Medication cassettes and monitoring are provided as needed.

*Crisis Intervention.* Access to crisis services is available 24 hours a day seven days a week. Participants are educated on how to access this service through a 1-800 number. The crisis response includes both telephone and face-to-face intervention based on the assessment of the Qualified Mental Health Professional on call. Patterns of instability and crisis are reviewed with the person by the treatment team and incorporated into the treatment plan. This is done so the person can develop an understanding of the crisis pattern and coping strategies can be developed to prevent chronic crisis situations. Hospital diversion is a major goal to these services. Access to community crisis beds is part of crisis services.

*Psychosocial Rehabilitation.* This is a group based service that provides skill building activities in areas such as independent living, leisure and recreation, development of social skills and supports and personal growth. These groups meet several times a week in a variety of community settings.

## OASIS Groups

- Recovery Skills
- Aftercare Group
- Recovery Engagement
- Twelve Step Study
- Relapse Prevention Group
- Process Group
- After Care Education
- DRA Support Group
- Recovery Enhancement Group

## VII. Issues Specific to Missouri





## **VII. Issues Specific to Missouri**

The preceding guidelines provide an overview of an ideal, integrated system of care for treating adults with co-occurring substance abuse and severe mental illness. Although the separate ADA and CPS divisions, with their concomitant separate treatment programs rules and regulations, certification, funding, and charting, may make developing integrated treatment programs very challenging, as noted in the vision, we feel that within the current system constraints, there are ways to develop integrated treatment programs. The two model programs just reviewed are examples that encompass most of the principles of integrated treatment within their CPRC/C-STAR based programs. However, significant changes also need to be made on a variety of levels in order for more integrated treatment programs to be developed and to provide more effective treatment services to consumers in Missouri. A committee of both DMH staff and state treatment providers could be charged with developing a list of rule and regulation-based changes that may be easily and quickly implemented to help remove some of the obstacles to developing and providing integrated treatment. In addition, the following are four major areas of systems level issues that the Team felt it important to address.

### **A. Funding for Integrated Treatment**

Funding for integrated treatment of co-occurring substance abuse and severe mental illness is complicated by the separate ADA and CPS systems that provide difficulties in integrating treatment. This results in several obstacles:

- Integrated treatment programs in mental health settings need to use their extremely limited funding to fund substance abuse treatment components.
- Substance abuse treatment programs do not have enough funding to provide some basic services for their primary target population, much less provide integrated treatment.
- Reimbursable services in mental health service contracts do not always accommodate integrated treatment services. For example, counseling under a CPS contract requires at least a Master's-level provider, while an ADA CSTAR contract allows for a bachelor's level provider. Also, current CPS contracts do not include "counseling" under CPRC, so there is no opportunity to leverage funds for this service.

There are several options for overcoming these barriers. The most fundamental changes require restructuring of DMH into a more streamlined and integrated system. Given that this level of change is not likely, practical options for agencies include the following:

- Currently, ADA provides group counseling, community support, individual counseling, and family therapy. CPS offers community support, psychosocial rehabilitation (Clubhouse), medication, testing, and psychiatrist's services.
- Use CPS contracts to fund the full range of psychiatric and substance abuse services. CPRC Medication, community support and PSR/educational groups can be used to maximize leveraging of funds. Individual and family counseling would have to be funded using straight POS.

- CPS providers with access to CSTAR contracts as either a direct contractor or subcontractor can blend funding streams by using CPS funds for medication, community support and crisis services and CSTAR funding for counseling and educational groups.

## **B. Paperwork and documentation**

The following is an example of how paperwork and documentation can be handled in an integrated treatment program. In 1997, Family Counseling Center approached the Department of Mental Health with a proposal to streamline charting on Co-Occurring clients. They proposed to combine the Alcohol and Drug chart and the Comprehensive Psychiatric Services chart because maintaining two separate charts was resulting in data duplication and was creating an inefficiency of staff time. In addition, it was difficult using two charts when assessing what the real needs of the client were. They decided that something had to be done to streamline the process, making it more useful and accurate to serve the needs of the client with co-occurring disorders.

They assembled a treatment team and assessed the paperwork and documents of both charts. The team then combined the information required for both programs and created one chart for clients with co-occurring disorders. The new, consolidated chart was presented to their Area Administrator and approved. They then presented the proposed consolidated chart to DMH. Both DMH divisions thought the combined chart would be more helpful in generating an improved understanding of the needs of clients, not only by facility staff, but also by the DMH reviewers.

## **C. Housing Options**

All people with disabilities should have the option to live in decent, stable, affordable and safe housing that reflects consumer choice and available resources (NASMHPD, 1996; *Position Statement on Housing and Supports for People with Psychiatric Disabilities*). Residential services are among the most important resources in a system of community-based mental health treatment and support services. However, housing shortages are a major gap in mental health systems nationally (U.S. Department of Health and Human Services, 1983).

Persons with co-occurring disorders need the opportunity to reside in a recovery-oriented environment that offers practical approaches to reducing the negative consequences of substance use and supports the individual in managing the symptoms of their mental illness. Recovery disorders environments demand interventions and policies designed to serve those with co-occurring in a manner that reflects individual and community needs.

In Missouri, there has been a concentrated effort to develop and expand independent housing options for DMH consumers, most notably through HUD (Section 8 and Shelter Plus Care) and Oxford Houses (resident-governed congregate housing for individuals with substance use disorders). Missouri DMH

also utilizes Residential Care Facilities (RCF) that typically provide room, board, basic nursing services and protective oversight and serve individuals with a range of disabilities along with the elderly. However, feedback from consumers, providers and advocates suggests that the current array of housing options within Missouri is inadequate to meet the needs of individuals with co-occurring disorders. The independent housing options do not offer sufficient structure and the RCF's are too large and too diverse for these individuals. Even with intense supports (daily visits) from community support workers, the stress of mental illness, disenfranchisement, and lack of community ties often lead clients to relapse, which may lead to eviction.

Housing options for consumers with co-occurring disorders must be designed to be supportive of their recovery, but prepared to address the realities of relapse and the process of re-engagement (Brown, Ridgely, Pepper, Levine, & Ryglewicz, 1989).

The following are components identified in a State of Arizona report (1999):

- Treatment programs and services should not be rigidly time-limited or limited to a strict progression from one phase to another.
- The length of stay in residential treatment should be individually based, rather than program-based.
- Shelter and housing should be provided with varying levels of supervision, depending on the needs of the individual client.

Housing must be phase-specific and appropriate to consumer preferences and functional capacity (CMHS, 1998).

- *“Wet” housing.* For difficult to engage individuals who are homeless and/or seriously impaired, yet not willing to change substance use behavior. Examples are psychiatrically supported shelters in which pre-motivational engagement, and initial psychiatric stabilization can begin.
- *“Damp” housing.* For consumers with mental illness symptoms that require significant staff support, but who are willing to limit substance use to promote a more manageable environment. Engagement and/or behavioral contracting can be used with clients who are more psychiatrically engaged.
- *“Dry” or “sober” housing.* For individuals who are committed to abstinence. This level is needed by many to foster initial abstinence and recovery support. Examples are modified therapeutic communities, staffed group homes, and relatively independent sober apartments. Sober housing programs may exclude clients who relapse, ideally after more than one episode. Outside case management by the primary care is needed to facilitate success, but also in the event of discharge.
- Consumers can move from wet to damp to dry (and back) as their needs and motivations change.
- Staff competency and intensity must match the level of disability of the residents and match the program mandate: sober (dry) housing staff need competency in substance recovery and relapse prevention; damp housing staff in motivational enhancement and substance education; wet housing staff in pre-motivational outreach and crisis management.

## D. Privacy Standards

### 1. Background Information

In enacting the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress mandated the establishment of standards for the privacy of individually identifiable health information. The Privacy Rule that became effective on April 14, 2001, established a federal floor of safeguards to protect the confidentiality of medical information. State laws, which provide stronger privacy protections, will continue to apply over and above the new federal privacy standards. Health care payers, clearinghouses, and providers must come into compliance with the new standards by April 2003.

### 2. Organized Health Care Arrangements

The Missouri Department of Mental Health (DMH) is committed to guaranteeing compliance with the standards of the Privacy Rule in such a manner as to ensure continuity and coordination of individual mental health and substance abuse treatment. As defined in the Privacy Rule, DMH and its contract providers are exploring the structure of an *Organized Health Care Arrangement*, in which all would jointly participate. This is an arrangement that provides health care in a clinically integrated setting and all entities participate in joint quality assessment and improvement activities. Additionally, under federal guidelines for substance abuse treatment providers, there is a similar concept referred to as a *Quality Service Organization*.

DMH promotes the provision of integrated services for those individuals with co-occurring mental health and substance abuse issues. Also, through its Certification and Licensure activities, as well as through its monitoring efforts, DMH conducts quality assurance activities.

### 3. Standardized Privacy Documents

Through the structure of an Organized Health Care Arrangement and/or the Quality Service Organization concept, DMH intends to develop standardized privacy documents for its contracted providers. These documents include: Consent to Treatment, Notice of Privacy Practices and Authorization to Release Information. It is anticipated that it will become a contractual requirement that all DMH providers use the standardized privacy documents.

## VIII. Dissemination and Implementation of Guidelines



## VIII. Dissemination and Implementation of Guidelines

### A. Principles in Planning System Change

Resistance may lie at the top levels of a system, or in the staff members who cling to the status quo, or it may be scattered throughout the system. Efforts to resist change might be overt and aggressive, or they might be passive, subtle, and insidious. At the opposite end of the scale is human motivation to change. This motivation might be internal—dissatisfaction with the status quo within an individual or an organization—or it might be external—outside pressure to change. As change agents, our challenge is to find and encourage others' motivation to change, while we hold onto our own. Successful technology transfer efforts are designed to help people explore, understand, and increase their motivation to change. When the motivation is strong enough, it can counter even strong resistance. Incentives might be thought of as ways of increasing motivation to change. These might be positive or negative rewards for successful change or the consequences of remaining stagnant.

One of the critical factors often overlooked in any systems-change process is the need for careful assessment of attributes associated with organizational change. D. Dwayne Simpson, Ph.D. has developed a number of organizational assessment instruments in his work in the Institute of Behavioral Research (IBR) at Texas Christian University (TCU).

*A dissemination plan is best developed by a multidisciplinary group of people. Wisdom shared by researchers and technology transfer experts follows.*

#### Planning

Steps in planning dissemination of practice guidelines for treatment of co-occurring disorders are:

##### 1. Problem Definition

- The biggest challenge.
- Assessing organizational/program staff readiness to change is recommended.
- Need consensus on what the problem is.
- Defining solution rests on agreement of problem definition.

## Quick Review: *The Change Book* Principles and Steps

### The Principles

Technology transfer plans must be relevant, timely, clear, credible, multifaceted, continuous, and bi-directional.

- **Relevant**—The technology in question must have obvious, practical applications.
- **Timely**—Recipients must acknowledge the need for this technology now or in the very near future.
- **Clear**—The language and process used to transfer the technology must be easily understood by the target audience.
- **Credible**—The target audience must have confidence in the proponents/sources of the technology.
- **Multifaceted**—Technology transfer will require a variety of *Activities* and formats suited to the various targets of change.
- **Continuous**—The new behavior must be continually reinforced at all levels until it becomes standard and then is maintained as such.
- **Bi-directional**—From the beginning of the change initiative, individuals targeted for change must be given opportunities to communicate directly with plan implementation.

(Quoted from Page 8 of *The Change Book*)

### The Steps

Step 1: Identify the problem.

Step 2: Organize a team for addressing the problem.

Step 3: Identify the desired outcome.

Step 4: Assess the organization or agency.

Step 5: Assess the specific audience(s) to be targeted.

**Step 6: Identify the approach most likely to achieve the desired outcome.**

Step 7: Design action and maintenance plans for your change initiative.

Step 8: Implement the action and maintenance plans for your change initiative.

Step 9: Evaluate the progress of your change initiative.

Step 10: Revise your action and maintenance plans based on evaluation results.

(Quoted from Page 9 of *The Change Book*)

## 2. Scope of Project Goals

- Beware of over ambitiousness.
- Do not attempt to change a whole system at once, instead, choose a small part of the system that's influential.
- Establish outcomes based on small successes.
- Do what's doable over a relatively brief period of time. Assess the priorities of the system and/or people involved in system, and address those priorities first.

## 3. Making a Commitment

- Be realistic about the amount of time and energy needed to disseminate the practice guidelines.
- Since committee member's task is to develop guidelines only, be aware of what other state support systems are available to assist in dissemination.

## 4. Carrying the Plan Forward

- Remain focused on desired goal/achievement.
- Develop a timeline—expect it to change. Be flexible.

## People

### 1. People-Work

- State leadership must support need for change. Without support from above, change will not occur.
- Identify those organizations/individuals who are early adopters of change, use them to form smaller coalitions and talk or work with them. Form partnerships with organizations and practitioners who support change.
- Identify those early adopters that will put their time and energy into championing the project.
- Consider if it would be easier to change policy than change the individuals and organizations involved.
- With the SA constituency and the MH constituency groups both involved, identify a goal both groups will view as worthwhile.
- Use task groups to recommend and tackle a few recommendations. Key stakeholders, diverse in terms of culture and gender, should be represented in task groups.

### 2. Incentives

- Develop incentives rewarding early adopters for participating in change process.
- Less-invested organizations will come along if rewards are visible for those who adopt change.
- Allow for feedback that demonstrates organizations are making progress.
- Make the stakeholders look good.
- Don't minimize the seemingly simple incentive of organizations wanting to do a better job and advancing the consumer's well being.



### 3. Resistance and Opposition

- Beware of the passive resistors in the system. Get them involved so they feel a part of the process and will become obligated to cooperate.
- Remember that some organizations and some individuals can't be won over, but their opposition and their resistance can be neutralized.
- In difficult situations where new circumstances are introduced (e.g., reduction in revenue), they may have to go back and redefine the problem.

### 4. "Managing Up"

- Manage the managers. If committee's recommendations are not supported from above, do not proceed with dissemination plans.
- Negotiate with the powers from above who are in the position of mandating change. Make change a win-win proposition.
- Develop strategies to deal with external pressure to "get things done now."

## B. Summary of Arizona Implementation Plan Process

### STEP ONE: The Consensus Panel

1. Developed a Vision Statement and a set of Principles.
2. Based on Vision and Principles, Goals were established.
3. Each Goal included general outcome statements.
4. Each Goal Statement lists more specific Objectives with multiple Strategies.
  - In Goals A-E, strategies were framed more as principles of treatment.
  - Goal F, Objective 1 Strategies tended to be more task oriented and outlined activities typically identified in adoption and dissemination plans.

### STEP TWO: Establishing an Implementation Structure

1. Arizona Department of Health (ADHS) changed policy and reflected those policy changes in funded-agency contracts (INCENTIVE).
2. ADHS began education process with "RBHAs." (Report does not define RBHAs)
3. ADHS created an Implementation Steering Committee. The committee's charge was to begin education and dissemination processes and implement the Consensus Panel recommendations.
4. ADHS created a Statewide Implementation Steering Committee to provide feedback to ADHS regarding implementation of recommendations across the state. Membership guidelines were defined.
5. ADHS created Local Consensus Panels to provide a forum for "identifying and resolving local implementation issues."
6. ADHS created an Evaluation Committee to develop an evaluation plan.

### **C. Grant submitted to the National Institute of Mental Health**

In June 2002, a grant was submitted to the National Institute of Mental Health (NIMH) under a program announcement titled “Dissemination of Mental Health Treatment” that would provide monies to disseminate the content of Practice Guidelines, most importantly the principles of integrated treatment, to state contracted mental health and substance abuse treatment agencies and their affiliates in Missouri. It is clear that there is a limited amount of funding available for informing providers about and providing training regarding integrated treatment. If the grant is awarded, it would provide funding for a number of different dissemination strategies to help educate providers. It will also provide information regarding which strategies are most effective, which may assist the DMH in using the most effective and cost-effective strategies in the future. The grant would be staffed by researchers from the Missouri Institute of Mental Health and University of Missouri School of Medicine, and DMH has provided two liaisons at 10% FTE.

The proposed project will use a randomized, longitudinal design to study the impact of several dissemination strategies on the adoption of the Practice Guidelines by state-contracted mental health and substance abuse services agencies and sites. Three strategies for disseminating Practice Guidelines will be developed: (a) an Internet site containing interactive learning modules, (b) a two-day training workshop, and (c) a one-day technical assistance visit. A decision regarding funding of this grant will be made by NIMH in January 2003.

## IX. Appendices



## IX. Appendices

### A. References

- Addiction Technology Transfer Centers. (2000). The change book: A blueprint for technology transfer. Author.
- Alexander M.J., & Muenzenmaier, K. (1998). Trauma, Addiction and Recovery, Addressing Public Health Epidemics Among Women with Severe Mental Illness. Women's Mental Health Services, A Public Health Perspective. Thousand Oaks, CA: Sage Publications, 215-239.
- American Liver Foundation. (1996). Getting Hip to Hep: What You Should Know About Hepatitis A, B, & C. <http://www.thebody.com/asp/nov01/hep.html>
- American Liver Foundation (2001). Who is at Risk for Hepatitis and Other Liver Diseases? [http://www.liverfoundation.org/html\\_filz/livheal\\_nu.htm](http://www.liverfoundation.org/html_filz/livheal_nu.htm)
- American Society of Addiction Medicine (1996). Patient placement criteria for the treatment of substance-related disorders (2<sup>nd</sup> ed.). Author.
- American Psychiatric Association (1980, 1987, 1994). Diagnostic and Statistical Manual of Mental Disorders (III, III-R, & IV Editions). Washington, DC: American Psychiatric Association.
- Arizona Integrated Treatment Consensus Panel. (1999). State of Arizona Service Planning Guidelines - Co-occurring Psychiatric and Substance Abuse Disorders, and Providing Integrated Services for Persons with Co-occurring Mental Health and Substance Abuse Disorders. Implementation Plan - Phase I. Author.
- Baker, F. (1993). Coordination of Alcohol, Drug Abuse and Mental Health Services. Washington, D.C., Center for Substance Abuse Treatment, Technical Assistance Publication Number 4.
- Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S. W., Moring, J., O'Brien, R., Schofield, N., & McGovern, J. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. American Journal of Psychiatry, 158, 1706-1713.
- Beeder, A., & Millman, R. B. (1997). Patients with psychopathology. In J. H. Lowinson, P. Ruiz, R. B. Millman & J. G. Langrod (Eds.) Substance abuse: A comprehensive textbook (3rd ed) (pp. 551-563). Baltimore, MD: Williams & Wilkins.
- Booth, B. M., Cook, C. L., & Blow, F. C. (1992). Comorbid mental disorders in patients with AMA discharges from alcoholism treatment. Hospital & Community Psychiatry, 43(7), 730-731.
- Brady, K. T., Halligan, P., & Malcolm, R. J. (1999). Dual Diagnosis. In M. Galanter & H. D. Kleber (Eds.) Textbook of Substance Abuse Treatment (pp. 475-483). Washington, DC: American Psychiatric Press.
- Broome, K. M., Simpson, D. D., & Joe, G. W. (1999). Patient and program attributes related to treatment process indicators in DATOS. Drug & Alcohol Dependence, 57, 127-135.
- Broner, R. K., King, V. L., Kidorf, M., Schmidt, C. W., & Bigelow, G. E. (1997). Psychiatric and substance use comorbidity among treatment-seeking opioid abusers. Archives of General Psychiatry, 54, 71-80.
- Brown, V. (1997). Breaking the Silence. Paper Presented at Prototypes Systems Change Meeting, Washington, DC.
- Brown, V. B., Ridgely, M. S., Pepper, B., Levine, I. S., et al. (1989). The dual crisis: Mental illness and substance abuse: Present and future directions. American Psychologist, 44, 565-569.
- Cantor-Graae, E., Nordstroem, L. G., & McNeil, T. F. (2001). Substance abuse in schizophrenia: A review of the literature and a study of correlates in Sweden. Schizophrenia Research, 48, 69-82.
- Carey, K.B. (1996). Substance use reduction in the context of outpatient psychiatric treatment: a collaborative, motivational, harm reduction approach. Community Mental Health Journal, 32, 291-306.
- Carroll, K.M., Nich, C., & Rounsaville, B. J. (1995). Differential symptom reduction in depressed cocaine abusers treated with psychotherapy and pharmacotherapy. Journal of Nervous & Mental Disorders, 183, 251-259.
- Caton, C. L. M., Shrout, P. E., Eagle, P. F., & Opler, L. A. (1994). Risk factors for homelessness among schizophrenic men: a case-control study. American Journal of Public Health, 84, 265-270.

Center for Mental Health Services. (1998). Clinical Standards and Workforce Competencies Project. Co-occurring Mental and Substance Disorders Panel. Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula. Kenneth Minkoff & Anne Rossi (panel chair and co-chairs).

Center for Substance Abuse Treatment. (1999). Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse, Treatment Improvement Protocol Series, Number 9. DHHS Publication No. (SMA) 99-3307. Rockville, MD: Department of Health and Human Services.

Center for Substance Abuse Treatment. (1995). Detoxification from Alcohol and Other Drugs, Treatment Improvement Protocol Series, Number 19. Department of Health and Human Services, DHHS Publication No. (SMA) 95-3046. Rockville, MD: Department of Health and Human Services.

Center for Substance Abuse Treatment. (1995). Pregnant, Substance-Using Women. DHHS Publication No. (SMA) 95-3056. Rockville, MD: Department of Health and Human Services.

Center for Substance Abuse Treatment. (2000). Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues. DHHS Publication No. (SMA) 00-3357. Rockville, MD: Department of Health and Human Services.

Centers for Disease Control and Prevention. (1997, March 24-26). NIH Consensus Conference, Bethesda, MD.

Compton, W. M., Cottler, L. B., Spitznagel, E. L., Abdallah, A. B., Gallagher, T. (1998). Cocaine users with antisocial personality improve HIV risk behaviors as much as those without antisocial personality. Drug & Alcohol Dependence, 49, 239-247.

Compton, W. M., Lamb, R. J., & Fletcher, B. W. (1995). Results of the NIDA treatment demonstration grants' cocaine workgroup: Characteristics of cocaine users and HIV risk behaviors. Drug & Alcohol Dependence, 37, 1-6.

Conger, R. D. (1997). The special nature of rural America. In E. B. Robertson, Z. Sloboda, G. M. Boyd, L. Beatty, & N. H. Kozel (Eds.). Rural substance abuse: State of knowledge and issues. Rockville, MD: National Institute on Drug Abuse, Research Monograph, No. 168.

Connecticut Certification Board, Inc. (2002). Co-occurring practitioners certificate of competence and certification manual. <http://www.ccb-inc.org/COOCCMANUAL.HTML> (01/16/02).

Cornelius, J., Sallous, I., Haskett, R., Ehler, J., Jarrett, P., Thase, M., & Perel, J. (1999). Fluoxetine versus placebo for the marijuana use of depressed alcoholics. Addictive Behaviors, 24, 111-114.

Dinwiddie, S. H., Reich, T., & Cloninger, C. R. (1992). Psychiatric comorbidity and suicidality among intravenous drug users. Journal of Clinical Psychiatry, 53(10), 364-369.

Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., Lynde, D., Osher, F. C., Clark, R. E., & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. Psychiatric Services, 52, 469-476.

Drake, R. E., McHugo, G. J., Clark, R. E., Teague, G. B., Xie, H., Miles, K., & Ackerson, T. H. (1998). Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. American Journal of Orthopsychiatry, 68, 201-215.

Drake, R. E. & Wallach, M. A. (2000). Dual diagnosis: 15 years of progress. Psychiatric Services, 51, 1126-1129.

Drake, R., Xie, H., McHugo, G., & Green, A. (2000). The effects of clozapine on alcohol and drug use disorders among patients with schizophrenia. Schizophrenia Bulletin, 26, 441-49.

Drake, R. E., Yovetich, N. A., Bebout, R. R., Harris, M., & McHugo, G. J. (1997). Integrated treatment for dually diagnosed homeless adults. Journal of Nervous & Mental Disease, 185, 298-305.

Edens, J. F., Peters, R. H., & Hills, H. A. (1997). Treating prison inmates with co-occurring disorders: An integrative review of existing programs. Behavioral Sciences and the Law, 15.

Godley, S.H., Hoewing-Roberson, R., & Godley, M. D. (1994). Final MISA Report. Bloomington, IL: Lighthouse Institute.

Goodwin, J., Cheeves, K., & Connell, V. (1988). Defining a syndrome of severe symptoms in survivors of severe incestuous abuse. Progress in the Dissociative Disorders, 1, 11-16.

Goodwin, S. (1995). Women and Mental Health. Los Angeles, CA: California Elected Women's Association for Education and Research Publication.

Greenfield, S. F., Weiss, R. D., & Tohen, M. (1995). Substance abuse and the chronically mentally ill: A description of dual diagnosis treatment services in a psychiatric hospital. Community Mental Health Journal, 31, 265-278.

- Hagan, T. A., Finnegan, L. P., & Nelson-Zlupko, L. (1994). Impediments to comprehensive treatment models for substance-dependent women: Treatment and research questions. Journal of Psychoactive Drugs, 26, 163-171.
- Harris, M., (1994). Modifications in service delivery for women diagnosed with severe mental illness who are also survivors of sexual abuse trauma. In M. Harris & C. Landis (Eds.) Sexual abuse in the lives of women with serious mental illness. New directions in therapeutic interventions, Vol. 2. India: Harwood Academic Publishers.
- Harris, M., (1996). Treating Sexual Abuse Trauma with Dually Diagnosed Women. Community Mental Health Journal, 32, 371-385.
- Health Insurance Portability and Accountability Act of 1996, PL 104-191, 42 U.S.C.
- Hellerstein, D. J., Rosenthal, R. N., & Miner, C. R. (1995). A prospective study of integrated outpatient treatment for substance-abusing schizophrenic patients. American Journal on Addictions 42, 33-42.
- Hertzman, M. (2000). Divalproex sodium to treat concomitant substance abuse and mood disorders. Journal of Substance Abuse Treatment, 18, 371-372.
- Hendryx, M. S., Borders, T., & Johnson, T. (1995). The distribution of mental health providers in a rural state. Administration & Policy in Mental Health, 23, 153-155.
- Heise, L., Ellsberg, M. & Gottemoeller, M. (1999, Dec). Ending Violence Against Women. Population Reports, Series L, No. 11. Baltimore, MD: Johns Hopkins University School of Public Health, Population Information Program.
- Ho, A. P., Tsuang, J. W., Liberman, R. P., Wang, R., Wilkins, J. N., Eckman, T. A., & Shaner, A. L. (1999). Achieving effective treatment of patients with chronic psychotic illness and comorbid substance dependence. American Journal of Psychiatry, 156, 1765-1770.
- Human, J., & Wasem, C. (1991). Rural Mental Health in America. American Psychologist, 46, 232-239.
- Jerrell, J. M., & Ridgely, M. S. (1995). Comparative effectiveness of three approaches to serving people with severe mental illness and substance abuse disorders. Journal of Nervous & Mental Disease, 183, 566-576.
- Kasser, C., Geller, A., Howell, E., & Wartenberg, A. (1998). Principles of Detoxification, In A. W. Graham & T. K. Schultz (Eds.) Principles of addiction medicine (2nd ed.) (pp. 423-30). Chevy Chase, MD: American Society of Addiction Medicine.
- Kessler, R. C., Crum, R. M., Warner, L. A., Nelson, C. B., Schulenberg, J., & Anthony, J. C. (1997). Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Survey. Archives of General Psychiatry, 54, 313-321.
- Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H-U., & Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Archives of General Psychiatry, 51, 8-19.
- King, V. L., & Brooner, R. K. (1999). Assessment and treatment of comorbid psychiatric disorders. In E. C. Strain & M. L. Stitzer (Eds.) Methadone treatment for opioid dependence. Baltimore, MD: Johns Hopkins University Press.
- Kleber, H. D. (1989). Treatment of drug dependence: What works. International Review of Psychiatry, 1, 81-99.
- Kranzler, H. R., Burleson, J. A., Korner, P., DelBoca, F. K., Bohn, M. J., Brown, J., & Liebowitz, N. (1995). Placebo-controlled trial of fluoxetine as an adjunct to relapse prevention in alcoholics. American Journal of Psychiatry, 152, 381-387.
- Kranzler, H. R., Del Boca, F. K., & Rounsaville, B. J. (1996). Comorbid psychiatric diagnosis predicts three-year outcomes in alcoholics: A posttreatment natural history study. Journal of Studies on Alcohol, 57, 619-626.
- Laarson, M. L., Beeson, P. G., & Mohatt, D. (1993). Taking rural into account. Report on the National Public Forum. Center for Mental Health Services, National Association for Rural Mental Health, Nebraska Department of Public Institutions. Lincoln, Nebraska.
- Lennox, R. D., Scott-Lennox, J. A., & Bohlig, E. M. (1993). The cost of depression-complicated alcoholism: Health-care utilization and treatment effectiveness. Journal of Mental Health Administration, 20, 138-152.
- Levin, F. R., Evans, S. M., Coomaraswamy, S., Collins, E. D., Regent, N., & Kleber, H. D. (1998). Flupenthixol treatment for cocaine abusers with schizophrenia: a pilot study. American Journal of Drug and Alcohol Abuse, 24, 343-60.

- Ley, A., Jefferey, D. P., McLaren, S., & Siegfried, N. (2000). Treatment programmes for people with both severe mental illness and substance misuse. The Cochrane Library, Issue 4.
- Mackenzie, A., Funderburk, F. R., & Allen, R. P. (1999). Sleep, anxiety, and depression in abstinent and drinking alcoholics. Substance Use & Misuse, 34, 347-361.
- Mason, B. J. (1996). Dosing issues in the pharmacotherapy of alcoholism. Alcohol: Clinical and Experimental Research, 20(7 Suppl), 10A-16A.
- McCarty, D., Argeriou, M., Huebner, R. B., & Lubran, B. (1991). Alcoholism, drug abuse, and the homeless. American Psychologist, 46, 1139-1148.
- McDowell, D., Levin, F., Seracini, A., & Nunes, E. (2000). Venlafaxine treatment of cocaine abusers with depressive disorders. American Journal of Drug and Alcohol Abuse, 26, 25-31.
- McGrath, P. J., Nunes, E. V., Stewart, J. W., Goldman, D., & Agosti, V. (1996). Imipramine treatment of alcoholics with primary depression: A placebo-controlled clinical trial. Archives of General Psychiatry, 53, 232-40.
- Mercer-McFadden, C., Drake, R. E., Brown, N. B., & Fox, R. S. (1997). The Community Support Program demonstrations of services for young adults with severe mental illness and substance use disorders, 1987-1991. Psychiatric Rehabilitation Journal, 20, 13-24.
- Miller, W. & Rollnick, S. (1991). Motivational interviewing: Preparing people to change addictive behavior. New York: Guilford.
- Minkoff, K. (2001). Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. Psychiatric Services, 52, 597-599.
- Minkoff, K. (2000). Service Planning Guidelines for Co-occurring Psychiatric and Substance Disorders for State of New Mexico.
- Minkoff, K. (2000). Service Planning Guidelines - Co-occurring Psychiatric and Substance Abuse Disorders [Edited Version] for State of Arizona.
- Mueller, T. I., Goldenberg, I. M., Gordon, A. L., Keller, M. B., & Warshaw, M. G. (1996). Benzodiazepine use in anxiety disordered patients with and without a history of alcoholism. Journal of Clinical Psychiatry, 57, 83-89.
- Mueser, K. T., Drake, R. E., & Noordsy, D. L. (1998). Integrated mental health and substance abuse treatment for severe psychiatric disorders. Journal of Practical Psychiatry and Behavioral Health, 4, 129-139.
- National Association of State Mental Health Program Directors/Center for Substance Abuse Treatment (1998). Responding to the Behavioral Healthcare Issues of Persons with Histories of Physical and Sexual Abuse. Author.
- National Association of State Mental Health Program Directors/National Association of State Alcohol and Drug Abuse Directors. (1998, July 17). Release report on preliminary information on services to individuals with co-existing substance abuse and mental health disorders. (<http://www.psychosocial.com/dualdx/comrbid1.html>)
- National Association of State Mental Health Program Directors/National Association of State Alcohol and Drug Abuse Directors. (1999, June). Financing and marketing the new conceptual framework for co-occurring mental health and substance abuse disorders. (<http://www.nasadad.org/Departments/Research/Consensus%20Framework/financial/>)
- National Association of State Mental Health Program Directors. (1996, July). NASMHPD Position Statement on Housing and Supports for People with Psychiatric Disabilities. Originally adopted by NASMHPD Membership, December 1987. Revised and adopted July, 1996.
- National Association of State Mental Health Program Directors Research Institute. (2002, January). Implementation of evidence-based services by state mental health agencies: 2001. State Profile Highlights, 11.
- National Center on Addiction and Substance Abuse at Columbia University (1999). No Safe Haven: Children of Substance-Abusing Parents. Author.
- National GAINS Center for People with Co-occurring Disorders in the Justice System (1997, Spring). Newsletter.
- Nunes, E. V., Quitkin, F. M., Donovan, S. J., Deliyannides, D., Ocepek-Welikson, K., Koenig, T., Brady, R., McGrath, P. J., & Woody, G. (1998). Imipramine treatment of opiate-dependent patients with depressive disorders. A placebo-controlled trial. Archives of General Psychiatry, 55, 153-160.
- Oregon Department of Human Services. (2000). Final report and recommendations. Department of Human Services Statewide Task Force on Dual Diagnosis.

- Oslin, D. W., Pettinati, H. M., Volpicelli, J. R., Wolf, A. L., Kampman, K. M., & O'Brien, C. P. (1999). The effects of naltrexone on alcohol and cocaine use in dually addicted patients. Journal of Substance Abuse Treatment, 16, 163-167.
- Owen, C., Rutherford, V., Jones, M., Tennant, C., & Smallman, A. (1997). Noncompliance in psychiatric aftercare. Community Mental Health Journal, 33, 25-34.
- Penick, E. C., Powell, B. J., Nickel, E. J., Bingham, S. F., et al. (1994). Co-morbidity of lifetime psychiatric disorder among male alcoholic patients. Alcoholism: Clinical & Experimental Research, 18, 1289-1293.
- Pollack, L. E., Cramer, R. D., & Varner, R. V. (2000). Psychosocial functioning of people with substance abuse and bipolar disorders. Substance Abuse, 21, 193-203.
- Primm, A. B., Gomez, M. B., Tzolova-Iontchev, I., Perry, W., & Crum, R. M. (2000). Chronically mentally ill patients with and without substance use disorders: A pilot study. Psychiatry Research, 95, 261-270.
- Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Kieth, S. J., Judd, L. L., & Goodwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiological Catchment Area (ECA) Study. JAMA, 264, 2511-2518.
- Ridgely, M. S., Goldman, H. H., & Willenbring, M. (1990). Barriers to the care of persons with dual diagnosis: Organizational and financial issues. Schizophrenia Bulletin, 16, 123-132.
- Ries, R., Mullen, M., & Cox, G. (1994). Symptom severity and utilization of treatment resources among dually diagnosed inpatients. Hospital & Community Psychiatry, 45, 562-568.
- Root, M. P. (1989). Treatment failures: The role of sexual victimization in women's addictive behavior. American Journal of Orthopsychiatry, 59, 542-549.
- Rosenberg, S. D., Goodman, L. A., Osher, F. C., Swartz, M. S., Essock, S. M., Butterfield, M. I., Constantine, N. T., Wolford, G. L., & Salyers, M. P. (2001). Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness. American Journal of Public Health, 91, 31-37.
- Ross, H. E., Glaser, F. B., & Germanson, T. (1988). The prevalence of psychiatric disorders in patients with alcohol and other drug problems. Archives of General Psychiatry, 45, 1023-1031.
- Sanchez, R. P., Kuo, J., Akin, D. R., Moore, R. P., & Bray, R. M. (June, 1999). State Demand and Needs Assessment Studies: Alcohol and Other Drugs. Integrating Population Estimates of Substance Abuse Treatment Need in Missouri. Prepared by Research Triangle Institute for the State of Missouri, Division of Alcohol and Drug Abuse.
- Sawyer, D. & Beeson, P. (1998). Rural Mental Health: 2000 & Beyond. National Association for Rural Mental Health.
- Scallet, L. J. (1996). Toward a Healthy Future: Women, Violence, and Mental Illness. Paper prepared for the National Women's Resource Center, Rockville, MD.
- Substance Abuse and Mental Health Services Administration/National Association of State Alcohol and Drug Abuse Directors. (1998). SAMHSA/NASADAD Release Report On Preliminary Information On Services To Individuals With Co-Existing Substance Abuse And Mental Health Disorders.
- Swift, R. M. (1999). Drug therapy for alcohol dependence. New England Journal of Medicine, 340, 1482-1490.
- Tatum, T. (1994). Rural Women's Recovery Program and Women's Outreach. Serving Rural Appalachian Women and Families in Ohio. Treating Alcohol and other Drug Abusers in Rural and Frontier Areas. SAMHSA-CSAT Technical Assistance Publication Series 17.
- U.S. Department of Justice, Bureau of Justice Statistics, 1996. Corrections statistics. <http://www.ojp.usdoj.gov/bjs/correct.htm>
- U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.
- U.S. Department of Health and Human Services. Report to Congress on Shelter and Basic Living Needs of Chronically Mentally Ill Individuals. Author: Washington D.C., 1983.
- Volavka, J. (1999). The effects of clozapine on aggression and substance abuse in schizophrenic patients. Journal of Clinical Psychiatry, 60(suppl. 12), 43-46.
- Watkins, K. E., Burnam, A., Kung, F-Y., & Paddock, S. (2001). A national survey of care for persons with co-occurring mental and substance use disorders. Psychiatric Services, 52, 1062-1068.



Wetherington, C. L. Smeriglio, V., L., & Finnegan, L. P. (1996). Behavioral studies of drug-exposed offspring: Methodological issues in human and animal research (NIDA Research Monograph No. 164). Rockville, MD: National Institute on Drug Abuse.

Wright, S., Gournay, K., Glorney, E., & Thornicroft, G. (2000). Dual diagnosis in the suburbs: Prevalence, need, and in-patient service use. Social Psychiatry & Psychiatric Epidemiology, 35, 297-304.

Yudofsky, S. C., Silver, J. M., & Hales, R. E. (2001). Treatment of agitation and aggression. In A. F. Schatzberg, & C. B. Nemeroff (Eds.) Essentials of Clinical Psychopharmacology. Washington, DC: American Psychiatric Publishing.

Ziedonis, D., & Trudeau, K. (1997). Motivation to quit using substances among individuals with schizophrenia: Implications for a motivation-based treatment model. Schizophrenia Bulletin, 23, 229-238.

Ziedonis, D., & Wyatt, S. (1998). Psychotic disorders. In A. W. Graham & T. K. Schultz (Eds.) Principles of Addiction Medicine (2<sup>nd</sup> ed.) (pp. 1007-1027). Chevy Chase, MD: American Society of Addiction Medicine.

Zimmet, S-V., Strous, R. D., Burgess, E. S., Kohnstamm, S., & Green, A. I. (200). Effect of clozapine on substance use in patients with schizophrenia and schizoaffective disorder: A retrospective study. Journal of Clinical Psychopharmacology, 20, 94-98.

## B. List of resources

The following is a brief list of organizations, websites, and discussion lists that provide further information on co-occurring disorders. In particular, the SAMHSA website is fairly exhaustive.

- The Addiction Technology Transfer Centers (<http://www.nattc.org/index.html>) provide resources and information for providers and agencies.
- The CO-OCCURRING DIALOGUES discussion list ([dualdx@treatment.org](mailto:dualdx@treatment.org)) is a free electronic discussion list which focuses on issues related to dual diagnosis.
- The Minkoff-chaired Center For Mental Health Services Managed Care Initiative: Clinical Standards And Workforce Competencies Project guidelines that were so essential in preparing the current Practice Guidelines are available as a downloadable PDF document (<http://www.uphs.upenn.edu/cmhpsr/PDF/CooccurringFinal.PDF>).
- The Missouri Institute of Mental Health's Policy Information Exchange, PIE On-Line is a free web-based database of primary source mental health policy documents (<http://www.mimh.edu/pie>). Search on keywords Dual Diagnosis or Best Practices.
- The National Alliance for the Mentally Ill (<http://www.nami.org>) is a great resource for consumers and family members.
- The New Hampshire-Dartmouth Psychiatric Research Center is a leader in developing integrated treatment for co-occurring disorders. (<http://www.dartmouth.edu/~dms/psychrc/index.html>)
- SAMHSA/CSAT's *Treatment Improvement Exchange* has a website for Co-occurring disorders topics (<http://www.treatment.org/Topics/dual.html>). The website includes lists of CSAT, NIDA, and NIAAA publications, other recent publications and government documents, and an extensive list of website links for co-occurring disorders.